UNITED BEHAVIORAL HEALTH
INDIVIDUAL PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT is between United Behavioral Health ("UBH") and the undersigned provider (hereinafter referred to as the "Provider"). This Agreement will become effective upon the date set forth in UBH's executed Acceptance Letter (the "Effective Date"). This Agreement sets forth the terms and conditions under which Provider shall participate in one or more networks developed by UBH as a Participating Provider of Covered Services to Members.

ARTICLE 1
DEFINITIONS

Any capitalized term herein shall have the meaning as set forth in this Agreement. Any undefined term herein shall have the meaning as defined in the Provider Manual, the Protocols, or as may be defined by applicable state or federal laws or regulations, as applicable.

Affiliate: Each and every entity or business concern with which UBH, directly or indirectly, in whole or in part, either: (i) owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Benefit Plan: The specific plan of benefits for health care coverage, including MHSA Services, for a particular Member that is provided, sponsored or administered by UBH directly or through its Affiliate, or through a network rental arrangement UBH may have with a third party, and contains the terms and conditions of a Member's coverage for MHSA Services, including applicable Member Expenses, exclusions and limitations, and all other provisions applicable to the coverage of such MHSA Services such as services rendered outside specified networks.

CMHC: A Community Mental Health Center.

CMHC Provider: An employee of a CMHC who provides mental health and/or substance abuse services, but is not a CMHC Supervising Provider.

CMHC Supervising Provider: A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MHSA Services are provided to Members who practices as an employee of CMHC and has been approved as a CMHC Supervising Provider in writing by UBH.

Covered Services: MHSA Services that meet the terms and conditions for coverage pursuant to the Member's Benefit Plan, including such conditions as Medically Necessary and proper authorization, and in accordance with the Provider Manual, Protocols, and applicable laws and regulations.

Customary Charge: The fee for MHSA Services charged by Provider that does not exceed the fee Provider would ordinarily charge any other person regardless of whether the person is a Member.

Emergency Services: Unless otherwise defined by applicable state law, a serious health condition that arises suddenly and requires immediate care and treatment, generally received within twenty-four (24) hours of onset, to stabilize or avoid jeopardy to the life or health of a

Member or, by actions of the Member, to the life or health of another. Emergency Services shall be available twenty-four (24) hours per day, seven (7) days per week.

Fee Maximums: The maximum amount Provider may receive as payment for provision of Covered Services to a Member, including Member Expenses, that are applicable to Provider pursuant to the Benefit Plan, as determined from time to time by UBH. UBH will advise Provider of the then-current Fee Maximums to Provider upon request.

Medicaid: A Medical Assistance Program providing health coverage benefits for low income persons pursuant to applicable state and federal laws and regulations.

Medically Necessary: Except as otherwise required by applicable state or federal law or regulations, for purposes of this Agreement, Medically Necessary means the term as it may be described in the Member's Benefit Plan for MHSA Services and which meets Payor's defined criteria for coverage as Covered Services. It may also, when applicable, have the meaning defined within the Protocols. Generally, however, Medically Necessary means treatment that is commonly recognized in the industry as consistent treatment that must be: (a) solely to treat the condition of the Member; (b) for the illness or injury of a diagnosis that is commonly recognized as a disease or injury; (c) reasonably expected to directly result in the restoration of health or function; (d) not experimental or investigational but is consistent with established and accepted national medical practice guidelines regarding type, frequency and duration of treatment; (e) without alternative treatment that is less intensive or invasive for the efficient treatment of the Member's condition; (f) not based on convenience for the Member; and (g) not otherwise excluded from the definition of Covered Services based upon the terms and conditions of the Member's Benefit Plan.

Medicare: Federally sponsored program providing health coverage benefits to individuals of qualifying age, disability, or disease.

Member: An individual who is eligible for, properly enrolled in, and covered under a Benefit Plan.

Member Expenses: Any amount of Customary Charges that are the Member's responsibility to pay Provider in accordance with the terms of the Member's Benefit Plan, including co-payments, co-insurance and deductible amounts.

Mental Health and Substance Abuse Services ("MHSA Services"): Health care services, treatment or supplies that are used to treat a mental health or substance abuse illness, condition or disease and which may be eligible for coverage under the Member's Benefit Plan.

Participating Provider: A health care professional, facility, CMHC Supervising Provider, psychiatrist, psychologist or other behavioral health professional or organization, that is duly licensed or certified to provide MHSA Services within the state such MHSA Services are provided, and who has a written Individual Participating Provider Agreement in effect with UBH, directly or through another entity, to provide MHSA Services to Members.

Payment Policies: Guidelines adopted by UBH, from time to time, for calculating payment of claims under Benefit Plans.

Payor: The entity or person that has the financial responsibility for funding payment of Covered

Services on behalf of a Member, and that is authorized to access MHSA Services in accordance with this Agreement.

Protocols: The programs, policies, protocols, processes, procedures, and requirements as such may change or be modified from time to time, and that are adopted by UBH or Payor, and which Provider agrees to follow as a condition of UBH accepting Provider as a Participating Provider, including, but not limited to, authorization procedures, credentialing and re-credentialing processes and plans, utilization management and care management processes, billing procedures, Payment Policies, providing or arranging for Emergency Services, quality improvement, peer review, on- site review, Member grievance and appeals processes, and any other policies, procedures, processes, activities or standards, wherever located as may apply to Provider's rights, obligations or responsibilities as a Provider of MHSA Services, whether in this Agreement, Provider Manual, or any other document as made accessible or available to Provider from time to time.

Provider Manual: A document or manual, however known or named, such as the Network Manual, containing the administrative policies, procedures and Protocols applicable to Benefit Plans provided, sponsored or administered by UBH or a Payor including, but not limited to, policies and procedures for credentialing, claims, quality improvement, and utilization management to which Provider is obligated.

ARTICLE 2
DUTIES OF PROVIDER

a. **Provision of MHSA Services.** Provider hereby acknowledges and agrees to cooperate and comply with all of the terms and conditions of the Provider Manual, Protocols, and this Agreement, and to dutifully perform as a Participating Provider for the provision of MHSA Services to Members within the UBH network(s) as designated by UBH or Payor. At the request of a Payor, Provider may not be authorized to provide MHSA Services for some or all of Payor's Members. Provider shall otherwise accept Members as new patients on the same basis as Provider is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. At all times, Provider shall require any employed or subcontracted health care professionals and facilities to comply with the terms and conditions of this Agreement, all Protocols of UBH and Payor, the Provider Manual, as well as the requirements of all applicable laws and regulations.

b. **Benefit Plan & Eligibility.** MHSA Services provided by Provider to a Member pursuant to this Agreement are subject to all the terms and conditions of the Member's Benefit Plan including eligibility of the Member on the date MHSA Services are provided to the Member. Provider shall make reasonable effort to verify Member's eligibility at time of service by following appropriate procedures, including without limitation, and at a minimum, the terms and conditions of this Agreement, Protocols, the Provider Manual, and review of the Member's Benefit Plan identification card. Provider however recognizes that the Member eligibility information may be inaccurate at the time Provider obtains verification and that the Member, or the MHSA Services

provided to the Member, may later be determined to be ineligible for coverage and, except as otherwise required by law, not eligible for payment under this Agreement. Under such circumstances, Provider may then, except as otherwise stated herein, directly bill the Member or other responsible party for such MHSA Services.

c. **Provider Manual & Protocols.** Provider shall be bound by, accept, strictly comply with, and cooperate with, the requirements set forth in the Provider Manual, credentialing plan, and all Protocols, as amended or modified from time to time by UBH and/or Payor, all of which are hereby incorporated herein by reference as if set forth fully herein, including without limitation quality improvement activities. Provider acknowledges and agrees that the Provider Manual and/or Protocols may contain service and contract requirements of certain Payors to which Provider shall strictly comply. Provider's failure to comply with the Provider Manual, Protocols and any other standards, procedures or policies may result in loss of, or reduction of payment or reimbursement to Provider, termination of this Agreement or the imposition of other corrective action by UBH.

d. **Authorization Requirements.** Subject to all applicable terms and conditions, including without limitation Section 2.2 above, and in accordance with the Provider Manual, Protocols, and requirements of the Member's Benefit Plan regarding authorization, Provider must request authorization for MHSA Services from UBH either telephonically or by another approved and accepted method recognized by UBH before providing any MHSA Services to a Member as a Covered Service. Authorizations shall subsequently be confirmed by UBH in writing. Except as otherwise permitted herein, only Emergency Services will be eligible for retroactive authorization at the sole discretion of UBH or as required by applicable law. Any authorization resulting from wrongful, fraudulent or negligent actions of Provider or a breach of this Agreement shall be null and void as of the time given.

e. **Provider's Standard of Care.** Nothing in this Agreement, the Provider Manual, the Benefit Plan, or the Protocols, including without limitation, UBH's utilization management and quality assurance and improvement standards and procedures, shall dictate MHSA Services provided by Provider or otherwise diminish Provider's obligation to freely communicate with and/or provide MHSA Services to Members in accordance with the applicable standard of care.

f. **Continuity of Care; Referral to Other Health Professionals.** Provider shall furnish Covered Services in a manner providing continuity of care and ready referral of Members to other Participating Providers at times as may be appropriate and consistent with the standards of care in the community. If a Member requires additional services or evaluation, including Emergency Services, Provider agrees to refer Member to his/her primary care physician or another Participating Provider in accordance with the terms and conditions of Member's Benefit Plan. A Member requiring Emergency Services shall also be referred to the "9-1-1" emergency response system.

g. **Member Access to Care.** Provider shall ensure that Members have timely and reasonable access to MHSA Services and shall at all times be reasonably available to Members as is appropriate. If Provider is unavailable when Members call, instructions must be provided for the Member referring the Member to another Participating Provider or to his/her Benefit Plan. Provider shall arrange for an answering machine or service that shall provide the office hours and emergency information and be capable of receiving messages 24 hours a day.

h. **Employees and Contractors of Provider.** Provider will be responsible for and shall ensure that all of its employees and contractors are bound by, and meet the terms and conditions of, this Agreement, the Provider Manual and Protocols, at the time of providing Covered Services to Members. Failure of such employees or contractors to meet such terms and conditions, including without limitation, credentialing requirements, UBH may restrict them from providing Covered Services to Members.

All payments obligated by Payor shall be paid to Provider and Provider will be solely responsible for payments to its employees and contractors who may have provided MHSA Services. Provider agrees to defend, indemnify and hold UBH harmless for any claims, damages, actions, or judgments arising from any employee or contractor of Provider related to the provision of MHSA Services to Members.

ARTICLE 3
PAYMENT PROVISIONS

1. **Payment for Covered Services.** In accordance with the terms and conditions hereof, Payor shall pay Provider for Covered Services provided to a Member by Provider. Payment shall be the lesser of: (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Fee Maximum for such MHSA Services, less any applicable Member Expenses.

Subject to the terms and conditions herein, the obligation for payment for Covered Services provided to a Member, less any applicable Member Expenses, is solely that of Payor. Additionally, UBH may arrange for claims processing services. When UBH is the Payor, UBH shall make obligated claim payments to Provider within 45 days (and shall use best efforts to encourage a third-party Payor to make payments within 45 days), or as otherwise required by law, of the date Payor receives all information necessary to process and pay a clean claim, except for claims for which there is coordination of benefits, Member Expense adjustments, disputes about coverage, systems failure or other such causes.

In the event a Member's Benefit Plan provides for a Member Expense whether stated as a flat fee or a percentage, the amount of the Member Expense shall be calculated in accordance with the Member's Benefit Plan or as determined by the Payor. The amount calculated pursuant to the preceding sentence shall be deducted from the amount Provider is to be paid for the Covered Services pursuant to this Agreement.

2. **Submission of Claims.** Provider shall submit claims for MHSA Services to UBH in a manner and format prescribed by UBH, whether in Protocols or otherwise, and which may be in an electronic format. All information necessary to process the claims must be received by UBH no more than 90 days from the date the

MHSA Services are rendered. Provider agrees that claims received after this time period may be rejected for payment, at UBH's and/or Payor's sole discretion.

Unless otherwise directed by UBH, Provider shall submit claims using current CMS (HCFA) 1500 or UB04 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Provider shall include in a claim the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number and/or other identifiers requested by UBH.

Payor shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

3. **Payment in Full.** Provider shall accept as payment in full for Covered Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement and shall not bill Members for non-covered charges, other than Member Expenses, which result from Payor's reimbursement methodologies. In no event shall Provider bill a Member for the difference between Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect Member Expenses from the Member. If Payor denies payment for services rendered by Provider on grounds that the services are not Medically Necessary, Provider shall not collect payment from the Member for the services unless the Member has knowledge of the determination of lack of Medical Necessity and has subsequently agreed in writing to be responsible for such charges and MHSA Services. Further, if any payment to Provider is denied, in part or full, due to Provider's failure to strictly comply with any term or condition in this Agreement, the Provider Manual, the Protocols, including without limitation, obtaining prior authorization, untimely filing of a claim, inaccurate or incorrect submission of or claim processing, or the insolvency of Payor pursuant to applicable law, it is agreed that Provider shall not, except for applicable Member Expenses, bill the Member or otherwise, directly or indirectly, seek or collect payment from the Member for any of the denied amounts. Any violation hereof by Provider shall be deemed a material breach. This provision shall apply regardless of whether any waiver or other document of any kind purporting to allow Provider to collect payment from the Member exists. These provisions shall survive the termination hereof and shall be construed to be for the benefit of the Member.

4. **Coordination of Benefits.** Provider shall be paid in accordance with Payor's coordination of benefits rules.

5. **Financial Responsibility.** In the event of a default (meaning a systematic failure by Payor to fund undisputed claim payments for Covered Services) by a Payor, except when due to the insolvency of Payor, UBH shall notify Provider in writing of such default following UBH's determination thereof. Any services which have been rendered by Provider prior to or after such notification, and which have not been paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Provider may seek payment directly from the Payor and Member for such services.

6. **Member Protection Provision.** This provision supersedes and replaces the Financial Responsibility section (section 3.5 above) only in those cases where UBH, or its Affiliate, is the Payor, or when required by another specific Payor, or when required pursuant to applicable laws, statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for MHSA Services rendered to Members by Provider, insolvency of Payor, or breach by UBH of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for MHSA Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member, any Member Expenses or charges for services that are not covered as benefits under the Member's Benefit Plan.

The provisions of this Article shall apply to all Member protection provisions in this Agreement and shall: (a) apply to all MHSA Services rendered while this Agreement is in force; (b) survive the termination of this Agreement regardless of the cause of termination; (c) be construed to be for the benefit of the Members; and (d) except as otherwise stated in section 3.3, supersede any oral or written agreement, existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such MHSA Services.

7. **Contracted Rate for Members.** Provider agrees to continue to provide MHSA Services to Members who have exhausted his/her Covered Services under the Benefit Plan and agrees not to collect or charge more than the contracted rate for those MHSA Services. Provider may bill the Member directly for those MHSA Services for which there is no longer any coverage under the Benefit Plan, in accordance herewith.

ARTICLE 4
LAWS, REGULATIONS, AND LICENSES, AND LIABILITIES OF PARTIES

1. **Laws, Regulations and Licenses.** Provider shall maintain in good standing all federal, state and local licenses, certifications and permits -- without sanction, revocations, suspension, censure, probation or material restriction -- which are required to provide health care services according to the laws of the jurisdiction in which MHSA Services are provided, and shall comply with all applicable statutes and regulations. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members, including covering Providers, comply with this provision.

2. **Responsibility for Damages.** Any and all damages, claims, liabilities or judgments, attorney fees, which may arise as a result of Provider's or its employee's or contractor's negligence or intentional wrongdoing shall be the sole responsibility of Provider.

3. **Provider Liability Insurance.** Provider shall procure and maintain, at Provider's sole expense, (a) medical malpractice or professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate if Provider is a Medical Doctor and $1,000,000 per occurrence and in aggregate if Provider is not a Medical Doctor; and (b) comprehensive

general and/or umbrella liability insurance in the amount of $1,000,000 per occurrence and in aggregate. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain malpractice insurance, unless they are covered under Provider's insurance policies.

Provider's and other health care professionals' medical malpractice insurance shall be on either an “occurrence” or “claims made” basis provided that for a “claims made” policy, such policy must be written with an extended period reporting option under such terms and conditions as may be reasonably required by UBH. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to UBH in writing evidence of insurance coverage.

ARTICLE 5
NOTICES

1. **Notices.** Provider shall notify UBH within ten (10) days of knowledge of any of the following:

    1. changes in liability insurance carriers, termination of, renewal of or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium;
    2. action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification or other material restriction on Provider's licenses, certifications or permits by any government under which Provider is authorized to provide health care services; and, of any suspension, revocation, condition, limitation, qualification or other material restriction of Provider's staff privileges at any licensed hospital, nursing home or other facility at which Provider has staff privileges during the term of this Agreement;
    3. a change in Provider's name, address, ownership or Federal Tax I.D. number;
    4. indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;
    5. claims or legal actions for professional negligence or bankruptcy;
    6. provider's termination, for cause, from any other provider network offered by any plan, including, without limitation, any health care service plan, health maintenance organization, any health insurer, any preferred provider organization, any employer or any trust fund;
    7. any occurrence or condition that might materially impair the ability of Provider to perform its duties under this Agreement; or
    8. any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff, or Members.

Unless otherwise specified in this Agreement, each and every notice and communication to the other party shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, on the date mailed, if delivered by first-class mail, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another address of which sending party has been notified, including without limitation, to UBH’s Network Manager at the

applicable address for notice as identified in the Provider Manual or Protocols. The parties shall, by written notice, provide and update each other with the most current address and names of all parties or designees that should receive certain notices or communication.

ARTICLE 6
RECORDS

1. **Confidentiality of Records.** UBH and Provider shall maintain the confidentiality of all Member information and records in accordance with all applicable state and federal laws, statutes and regulations, including without limitation, the Health Insurance Portability and Accountability Act.

2. **Maintenance of and UBH Access to Records.** Provider shall maintain adequate medical, treatment, financial and administrative records related to MHSA Services provided by Provider under this Agreement for a period and in a manner consistent with the standards of the community and in accordance with the Provider Manual, Protocols and all applicable state and federal laws, statutes and regulations.

In order to perform its utilization management and quality improvement activities, UBH shall have access to such information and records, including claim records, within 14 days from the date the request is made, except that in the case of an audit by UBH, such access shall be given at the time of the audit. If requested by UBH, Provider shall provide copies of such records free of charge. During the term of this Agreement UBH shall have access to and the right to audit information and records to the extent permitted by the Provider Manual, or as otherwise required by state or federal laws, statutes or regulations or regulatory authority. Said rights shall continue following the termination hereof for the longer of three years or for such period as may be permitted by applicable state or federal law, regulatory authority, or Protocols.

It is Provider's responsibility to obtain any Member's consent in order to provide UBH with requested information and records or copies of records and to allow UBH to release such information or records to Payors as necessary for the administration of the Benefit Plan or compliance with any state or federal laws, statutes and regulations applicable to the Payors.

Provider acknowledges that in receiving, storing, processing or otherwise dealing with information from UBH or Payor about Members, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and Provider agrees that it will resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

This section shall not be construed to grant UBH access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 6.3.

3. **Government and Accrediting Agency Access to Records.** It is agreed that the federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their authorized representatives, shall have access to, and UBH and Provider

are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of UBH or Provider, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to UBH, Payor or Provider. Such access shall be available and provided during the term of this Agreement and for three years following the termination hereof, or such longer period as may be identified in the Provider Manual or Protocols or as required by applicable state or federal laws, statutes or regulations.

ARTICLE 7
RESOLUTION OF DISPUTES

7.1 Resolution of Disputes. It is agreed that prior to any other remedy available to the parties, UBH, Payor and/or Provider shall provide written notice of any disputes or claims arising out of their business relationship (the "Dispute") to the other party within thirty (30) days of the final decision date, action, omission or cause from which the Dispute arose, whichever is later (the "Dispute Date"). If the Dispute pertains to a matter which is generally administered by certain UBH procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke his or her rights as described herein. After receipt of the written notice of the Dispute, the parties agree to work together in good faith to resolve the Dispute. If the parties are unable to resolve the Dispute within thirty (30) days following receipt of the notice of the Dispute, and if either UBH, Provider or Payor desires to pursue formal resolution of the Dispute, then said party shall issue a notice of arbitration to the other parties. It is agreed that the parties knowingly and voluntarily waive any right to a Dispute if arbitration is not initiated within one year after the Dispute Date.

Any arbitration proceeding under this Agreement shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association ("AAA"), and shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

ARTICLE 8
TERM AND TERMINATION

1. **Term.** This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated in accordance with the provisions herein.

2. **Termination.** This Agreement may be terminated as follows:

    1. by mutual agreement of UBH and Provider;
    2. by either party upon 90 days prior written notice to the other party;
    3. by either party, in the event of a material breach of this Agreement by the other party, upon 30 days prior written notice to the other party. The written notice shall specify the precise nature of the breach. In the event

the breaching party cures the breach to the reasonable satisfaction of the non- breaching party, within 30 days after the non-breaching party's written notice, this Agreement shall not terminate;

4. by UBH immediately upon written notice to Provider, due to Provider's loss, suspension, restriction, probation, voluntary relinquishment, or any other adverse action taken against any of Provider's licenses or certification, or loss of insurance required under this Agreement;
5. by Provider upon 60 days prior written notice to UBH due to a unilateral amendment made to this Agreement pursuant to section 9.1;
6. by UBH in accordance with its credentialing plan;
7. by UBH immediately if UBH determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement; or
8. by UBH in accordance with the Provider Manual or Protocols.

During periods of notice of termination, UBH reserves the right to transfer Members to another Participating Provider, and Provider agrees to cooperate and assist with such transfers. If Provider is terminated through the UBH credentialing or recredentialing process, this Agreement shall be deemed terminated as of the date Provider has been terminated pursuant to a final action resulting from that process.

3. **Information to Members.** Provider acknowledges and agrees that UBH has the right to inform Members of Provider's termination and/or the notice of termination to Provider, and agrees to cooperate with UBH in matters concerning the termination/transition, and agrees to hold UBH harmless for exercising its rights hereunder. Provider also agrees to clearly inform Members of Provider's impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date.

4. **Continuation of Services After Termination.** At the option of UBH, Provider shall continue to provide MHSA Services authorized by UBH to Members who are receiving such services from Provider as of the effective date of termination of this Agreement, until Member can be satisfactorily transferred to another Participating Provider. Payor shall continue to pay Provider for such services at Provider's contracted rate.

ARTICLE 9
MISCELLANEOUS

1. **Amendment.** UBH may amend this Agreement by sending notice of the amendment to Provider at least 30 days prior to its effective date. The Provider's signature is not required. It is agreed that this Agreement shall be automatically amended to comply with any and all applicable state or federal laws, regulations, statutes or the requirements of applicable regulatory authorities as of the effective date thereof, and which shall be deemed to be incorporated herein by reference as of its effective date. Likewise, if a Payor that is a governmental entity requires that certain provisions of this Agreement be removed, replaced, amended or that additional provisions be incorporated, such provisions shall be deemed to be removed, replaced, amended or additional provisions incorporated into this Agreement as of the effective date of such Payor requirement for all MHSA Services provided which are subject to such Payor requirements without the

signature of Provider being required.

2. **Assignment.** UBH may assign all or any of its rights and responsibilities under this Agreement to any of its Affiliates. Provider may assign any of his or her rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of UBH, which consent shall not be unreasonably withheld.

3. **Administrative Responsibilities.** UBH may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, its Affiliate or to Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

4. **Relationship Between UBH and Provider.** The relationship between UBH and Provider is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, joint venture or partnership.

5. **Name, Symbol and Service Mark.** During the term of this Agreement, Provider, UBH and Payor shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, UBH and Payor shall not otherwise use each other's name, symbol or service mark or that of their Affiliates without the prior written approval from the appropriate party.

6. **Confidentiality.** Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, Protocols and programs; except that (a) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates; (b) UBH may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Plan, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law; and (c) UBH shall be permitted to disclose, in its sole discretion, any other data or information that may be requested by applicable state and federal law, state regulations or governing agencies that pertain to this Agreement or that may relate to the enforcement of any right granted or term or condition of this Agreement.

7. **Communication.** UBH encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member’s Benefit Plan. Nothing in this Agreement is intended to interfere with Provider’s relationship with Members as patients of Provider, or with UBH’s ability to administer its quality improvement, utilization management and credentialing programs.

8. **Effects of New Statutes and Regulations and Changes of Conditions.** The parties agree to re-negotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a change in laws or regulations, a requirement that one party comply with an existing law or regulation contrary to the other party's prior reasonable understanding, or a change in UBH's arrangements with Payors. The party affected must promptly notify the other party

of the change or required compliance and its desire to re-negotiate this Agreement. If a new agreement is not executed within 30 days of receipt of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement upon 45 days prior written notice to the other party. Any such notice of termination must be given within 10 days following the expiration of the 30-day re-negotiation period.

9. **Appendices.** Additional and/or alternative provisions, if any, related to certain MHSA Services rendered by Provider to Members covered by certain Benefit Plans are set for in the Appendices.

10. **Entire Agreement.** On the Effective Date, this Agreement supersedes and replaces any existing Provider Agreements between the parties related to the provision of MHSA Services, including any agreements between Provider and Affiliates of UBH for MHSA Services. This Agreement, together with any and all documents referenced herein, attachments, addenda, appendices, as may be amended or modified from time to time, whether contemporaneous or subsequently made pursuant to Section 9.1, are hereby incorporated herein by reference, and constitutes the entire agreement between the parties in regard to its subject matter (herein collectively referred to as this "Agreement").

11. **Strict Compliance.** The waiver of strict compliance or performance of any of the terms or conditions of this Agreement, the Provider Manual or the Protocols or of any breach thereof shall not be held or deemed to be a waiver of any subsequent failure to comply strictly with or perform the same or any other term or condition thereof or any breach thereof.

12. **Severability.** Should any provision of this Agreement violate the law or be held invalid or unenforceable as written by a court of competent jurisdiction, then said provision along with the remainder of this Agreement shall nonetheless be enforceable to the extent allowable under applicable law by first modifying said provision to the extent permitted so as to comply with applicable law; otherwise said provision shall be deemed void to the extent of such prohibition without invalidating the remainder of this Agreement.

13. **Rules of Construction.** In the event of any conflict between the terms of this Agreement and the terms of any other agreement or any other controlling document or any applicable state or federal laws, statutes and regulations relating to the subject matter hereof, the terms, except as otherwise expressly stated herein, shall first be read together to the extent possible; otherwise the terms that afford the greater protections to first UBH and second to the Benefit Plan shall prevail over the conflicting term, to the extent permitted by, in accordance with and subject to applicable law, statutes or regulations. The remainder of the Agreement shall otherwise remain without invalidating or deleting the remainder of the conflicting provision or the Agreement.

14. **Governing Law.** This Agreement shall be governed by and construed in accordance with applicable state and federal laws, statutes and regulations, including without limitation, ERISA.

15. **Medicaid Members.** If a Medicaid Appendix is attached to this Agreement

Provider agrees to provide MHSA Services to Members enrolled in a Benefit Plan for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

16. **Medicare Members.** If a Medicare Appendix is attached to this Agreement, Provider agrees to provide MHSA Services under this Agreement, to Members who are enrolled in a Benefit Plan for Medicare beneficiaries and to cooperate and comply with the provisions set forth in the attached Medicare Advantage Addendum. Provider also understands that UBH's agreements with Participating Providers are subject to review and approval by the Centers for Medicare and Medicaid Services ("CMS").

17. **Survival.** Upon any termination or expiration of this Agreement, the provisions herein which contemplates performance or observance subsequent to termination or expiration, including without limitation, sections 3.1, 3.2, 3.3, 3.6, 8.3, 8.4, 9.6 and Articles 6 and 7, shall survive and remain of full force and effect between the parties.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

Sarah Lustig
1131 Wando Rd
Charleston, SC
29492-7854

Attn:	Sarah Lustig
Signature:	Sarah Lustig R.N., Rehab Nurse (Jan 18, 2023 10:58 EST)
Print Name:	Sarah Lustig R.N., Rehab Nurse
Title:	Registered Nurse
Date:	Jan 18, 2023
Federal Tax ID Number:	882362401
Medicare Number:	
Medicaid Number:	
NPI Number:	1952038580

Agreement Number: 00914436.0

South Carolina Regulatory Appendix

This **South Carolina** Regulatory Requirements Appendix (the "Appendix") is made part of this Agreement entered into between United Behavioral Health ("UBH") and the health care professional named in this Agreement ("Provider").

This Appendix applies to all products or Benefit Plans sponsored, issued or administered by or accessed through UBH to the extent such products are regulated under South Carolina laws; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

UBH and Provider each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix shall control, except with regard to Benefit Plans outside the scope of this Appendix, and be read in accordance with applicable laws and regulations.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts"; "Member," as used in this Appendix, will have the same meaning as "member," "enrollee," or "covered person"; "Payor," as used in this Appendix, will have the same meaning as "participating entity"; "Provider," as used in this Appendix, will have the same meaning as "Facility," "Medical Group," "Ancillary Provider," "Physician," or "Practitioner." Additionally, if the Agreement uses pronouns to refer to the contracted entities, then "UBH" will have the same meaning as "we" or "us," and "Provider" will have the same meaning as "you" or "your."

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix shall be defined as set forth in the Agreement.

1. Arbitration. PROVIDER AGREES THAT THIS APPENDIX AND AGREEMENT ARE SUBJECT TO ARBITRATION IN ACCORDANCE WITH THE SOUTH CAROLINA UNIFORM ARBITRATION ACT (Title 15, Chapter 48 of South Carolina Statutes).

2. No Gag Clause. Provider and UBH agree that nothing in this Agreement shall be construed to limit Provider's ability to discuss with a Member the treatment options available to that Member, risks associated with treatments, utilization review/utilization management decisions, or recommended course of treatment, and nothing in this Agreement shall limit Provider's legal obligations to a Member as specified under Provider's professional license. However, nothing in this section shall prevent UBH from prohibiting disclosure of trade secrets by Provider.

3. Legal Responsibility. Provider and UBH agree that each is responsible for the legal consequences and costs of its own acts or omissions, or both, and is not responsible for the acts or omissions, or both, of the other party. However, nothing in this section shall be construed to
subject UBH to liability for clinical decisions made solely by Provider, and nothing in this section limits that ability of UBH to otherwise prudently administer its provider contracts.

4. Professional Liability Insurance. Provider shall be considered adequately insured for the purposes of this Agreement if Provider has procured liability insurance from the South Carolina Medical Malpractice Joint Underwriting Association and the Patients' Compensation Fund.

5. Notice Regarding Professional Liability Insurance. Provider shall notify UBH within ten (10) days of any material change in liability insurance coverage or carrier (including the South Carolina Medical Malpractice Joint Underwriting Association and the Patients' Compensation Fund), including but not limited to, termination, nonrenewal, reduction of limits, erosion of aggregate, changes in retention or non-payment of premium.

6. Payment of Claims.

i) UBH or Payor will adjudicate and pay claims in accordance with the South Carolina Health Care Financial Recovery and Protection Act (S.C. Code of Laws, Title 38, Chapter 59, Article 2). UBH or Payor will pay a clean claim that is submitted via paper within forty (40) business days, or submitted electronically within twenty (20) business days, following the later of UBH's receipt of the claim or UBH's receipt of all information needed and in a format required for the claim to constitute a clean claim, and UBH's receipt of all documentation requested by UBH which is reasonably needed: (1) to determine that such claim does not contain any material defect, error, or impropriety; or (2) to make a payment determination.

ii) If UBH determines that there is a defect, error, or impropriety in a claim that prevents the claim from adjudication, UBH shall notify Provider of the defect or error (or Provider's designated vendor for the exchange of electronic health transactions) within twenty business days of the submission of an electronic claim or within forty business days of the submission of a paper claim. Nothing contained in this section is intended or may be construed to alter UBH's ability to request clinical information reasonably necessary for the proper adjudication of the claim or for the purpose of investigating fraudulent or abusive billing practices.

iii) For each clean claim paid later than the applicable period specified above, UBH or Payor shall pay interest in the same manner and at the same rate set forth in S.C. Code Ann. § 34-31-20 on the balance due on each claim computed from the twenty-first or the forty-first business day, as appropriate, up to the date on which UBH directs the issuance of the check or the electronic funds transfer for payment of the clean claim. At UBH's election, such interest paid must be included in the claim payment check or wire transfer or must be remitted periodically, but at least quarterly, in a separate check or wire transfer along with a report detailing the claims for which interest is being paid. UBH or Payor is not obligated to pay interest: (1) if within the applicable adjudication period of twenty or forty days of submission of the original claim, a duplicate claim is submitted while the original claim is still in process; (2) if Provider balance bills a Member in violation of this Agreement; (3) with respect to any time period during which a force majeure prevents the adjudication of claims; or (4) when payment is made to a Member.

iv) UBH shall initiate any overpayment recovery efforts by sending a written notice to Provider at least thirty business days prior to engaging in the overpayment recovery
efforts, other than for recovery of duplicate payments or other similar adjustments relating to:

a) claims where Provider has received payment for the same services from another payor whose obligation is primary; or
b) timing or sequence of claims for the same Member that are received by UBH out of chronological order in which the services were performed.

The written notice required by this section 6(d) shall include:
a) the patient's name;
b) the service date;
c) the payment amount received by Provider; a reasonably specific explanation of the change in payment; and
d) the telephone number or a mailing address through which Provider may initiate an appeal, and the deadline by which an appeal must be received.

v) UBH may not initiate overpayment recovery efforts more than eighteen months after the initial payment was received by Provider; however, this time limit does not apply to the initiation of overpayment recovery efforts:

a) based upon a reasonable belief of fraud or other intentional misconduct;
b) required by a self-insured plan; or
c) required by a state or federal government program.

7. Continuation of Care. If the Agreement is not renewed or is terminated by either party, the parties will comply with the following in accordance with South Carolina Code Ann. § 38-71243:

i) UBH is liable for covered benefits rendered by a continuation of care provider for serious medical condition, subject to the policy's or contract's regular benefit limits.

ii) In-network deductibles and copayments apply to continuation of care services.

iii) UBH may not require a greater premium payment or contribution by covered person in order to provide continuation of care benefits for the covered person or their dependents.

iv) Provider will accept the negotiated rate from the provider contract as payment in full for services rendered within the continuation of care.

v) Provider will not bill or hold the covered person financially responsible beyond the applicable deductible or copayment, unless Provider has not received payment at the negotiated rate described above.

vi) Upon receipt of patient's request accompanied by the physician's attestation on the prescribed form, UBH will notify the provider and the covered person of the provider's date of termination from the network, and of these continuation of care provisions.

vii) UBH is responsible to determine if the covered person qualifies for continuation of care and may request additional information in order to reach that determination.

Amendment to
United Behavioral Health Provider Participation Agreement for
VA Community Care Program

United Behavioral Health, operating under the brand Optum ("UBH"), and Provider are parties to a Provider Participation Agreement (the "Agreement") under which Provider participates in UBH's network of participating providers.

This amendment to the Agreement (this "**Amendment**") is the effective date of the provider's contract (the "**Amendment Effective Date**").

RECITALS

A. Optum Public Sector Solutions, Inc. ("Optum") is a UBH Affiliate.
B. Optum, in response to solicitation number VA791-16-R-0086, submitted a bid to the UBH States Government to provide a Community Care Network ("VA CCN") for the Department of Veterans Affairs (the "VA") on a self-funded basis for the provision of health and administrative services to Enrolled Eligible Veterans (as defined below). In response to Optum's bid, Optum was awarded a Prime Contract by the VA for VA CCN Region [insert applicable Region] (the "Prime Contract").
C. UBH wants to make Provider's services available to Enrolled Eligible Veterans, and Provider wishes to provide those services, under the terms and conditions set forth in this Amendment.
The parties to this Amendment agree to the following:

ARTICLE I
DEFINITIONS

The following terms when used in this Amendment have the meanings set forth below. Capitalized terms in this Amendment but not defined in this Amendment will have the meaning set forth in the Agreement. If there is a conflict between the terms of the Agreement and this Amendment concerning the VA CCN, the term set forth in this Amendment will govern for the VA CCN.

1.1 **Approved Referral**. An Approved Referral constitutes an authorized service under the VA CCN Requirements (as defined below). Approved Referrals will support a specific plan of care as it relates to a specified number or visits and/or services approved for the individual Enrolled Eligible Veteran over a specified period of time not to exceed one (1) year.

1.2 **Enrolled Eligible Veteran**. A person who is enrolled in VA's patient enrollment system established and operated under 38 U.S.C. Section 1705, and is eligible to receive care in the community as determined by the VA.

1.3 **Clean Claim**. A Clean Claim means a claim for payment for Contracted Services that contains all the required data elements necessary for adjudication, without requesting supplemental information from the submitter, as required by the VA CCN Requirements.

1.4 **Contracted Services**. Covered Services that are within Provider's scope of practice and provided to an Enrolled Eligible Veteran pursuant to VA CCN Requirements in effect at the time services are rendered and compensated in accordance with this Amendment and VA CCN Requirements.

1.5 **Covered Services**. The health care services and supplies that are covered under the VA CCN as described in 38 CFR 17.38 and for which Provider has received an Approved Referral or Prior Authorization.

1.6 **Days**. All days referenced in this Amendment and its Exhibits or in the Provider Manual are calendar days unless otherwise noted.

1.7 Emergent Care. Medical care required within twenty-four (24) hours or less essential to evaluate and stabilize conditions of an emergent need that if not provided may result in unacceptable morbidity/pain if there is significant delay in the evaluation or treatment.

1.8 Emergent Healthcare Need. Conditions of one's health that may result in the loss of life, limb, vision, or result in unacceptable morbidity/pain when there is significant delay in evaluation or treatment.

1.9 Standardized Episode of Care. A set of clinically related healthcare services for a specific unique illness or medical condition (diagnosis and/or procedure) provided by an authorized provider during a defined authorized period of time not to exceed one (1) year.

1.10 Provider. A facility, ancillary provider, physician, physician organization, other health care professional, supplier, or other entity engaged in the delivery of health care services which is licensed and/or certified as required under applicable law, and which has been duly credentialed by UBH or its designee and is subject to an effective written Amendment directly with UBH, or indirectly through another entity (such as another provider), to provide Covered Services to Eligible Veterans.

1.11 Provider Manual. The VA Community Care Network Provider Manual (the "Provider Manual") is added to Table 1 in the Additional Manuals Appendix of the Agreement, and will be an "Additional Manual," as that term is defined in the Additional Manuals Appendix. It will include manuals and handbooks provided by the VA or UBH for use by Providers. The Provider Manual will be updated from time to time, and UBH may implement changes to the Provider Manual without Provider's consent if the change is applicable to all or substantially all providers of the same type offering similar services in UBH's VA CCN. Such changes will be communicated to providers through amendments, updates at vacommunitycare.com or its successor, provider newsletters, bulletins or supplemental manuals or handbooks. If a change to the Provider Manual is material, UBH will use reasonable commercial efforts to inform Provider via written or electronic notice thirty (30) days in advance of the material change, unless a shorter period is necessary to meet UBH's obligations to the VA.

1.12 Prior Authorization. A required process through which VA reviews and approves certain medical services to ensure the medical necessity and appropriateness of care prior to services being rendered within a specified timeframe from a non-VA provider or additional resources in the community. This type of process requires Prior Authorization to be obtained "prior to" the specified service.

1.13 Provider Professional. The physicians, practitioners, and allied health professionals who have been accepted by UBH to provide Contracted Services to Enrolled Eligible Veteran.

1.14 Reimbursement Rate. The payment made to Provider for Covered Services provided to an Enrolled Eligible Veteran as set forth in the Payment Appendix to this Amendment. The Reimbursement Rate is calculated in accordance with the VA CCN Requirements. In no event will the Reimbursement Rate exceed the maximum allowed by the VA CCN Requirements.

1.15 State. The state or states in which Provider is to provide Covered Services under this Amendment.

1.16 UBH VA CCN Policies. The policies, procedures and programs utilized by UBH for VA CCN and applicable to Provider in effect at the time services are rendered to an Enrolled Eligible Veteran, including, without limitation, the Provider Manual, credentialing and quality management and improvement programs, fraud detection and recovery procedures, eligibility verification, payment and coding guidelines, anti-discrimination requirements, utilization management, case management and disease management plans and programs, grievance and appeal procedures, consultation report policy and procedure, and provider dispute and/or administrative review processes. The UBH VA CCN Policies are documented and may be modified from time to time through revisions, supplements, modifications or amendments, and Provider may be made aware of those modifications through written or electronic notice via modification notices, amendments, provider newsletters, updates at vacommunitycare.com or its successor, bulletins or supplemental releases.

1.17 **VA CCN Requirements**. VA CCN Requirements shall mean laws, regulations, and requirements applicable to VA CCN, as may be amended, including but not limited to Title 38, UBH States Code, Chapter 81, Title 38 Code of Federal Regulations, Chapter 1, Part 17, the Prime Contract, and the UBH VA CCN Policies.

1.18 **VA Benefit Plan**. Benefit Plans sponsored, issued, or administered by the VA for veterans enrolled in the patient enrollment system established and operated by the VA under 38 U.S.C. Section 1705.

ARTICLE II.
PROVIDER OBLIGATIONS

2.1 **Provision of Services**. Provider will render Contracted Services to Enrolled and Eligible Veterans, in accordance with the terms and conditions of this Amendment, including all VA CCN Requirements. Provider shall be solely responsible for the quality of Contracted Services rendered by Provider to Enrolled Eligible Veterans. In the event Provider or Provider Professional is uncertain as to whether a service is a Covered Service, the Provider or Provider Professional shall contact the VA, as directed in the Provider Manual and vacommunitycare.com or its successor to obtain a coverage determination prior to rendering services, except in an Emergent Healthcare Need.

2.2 **Provider Education**. Provider shall participate in, and shall require all Provider Professionals to participate in, the VA CCN education efforts described in the Provider Manual. ,.

2.3 **Credentialing of Provider Professionals.** Provider shall ensure that each Provider Professional submits to UBH, or its designee, a credentialing application which meets the requirements of UBH, to the extent they are subject to credentialing. The credentialing application must be approved by UBH or its designee prior to any performance taking place by such Provider or Provider Professional under this Amendment.

2.4 **Office Availability/Access.** Provider shall maintain such offices, equipment, patient service personnel and allied health personnel as may be necessary to provide Contracted Services. Provider shall provide Contracted Services under this Amendment at Provider's offices during normal business hours, and shall be available, or obtain coverage referenced in Section 2.5, to Enrolled Eligible Veterans by telephone twenty-four (24) hours a day, seven (7) days a week for consultation on medical concerns. Further, Provider shall be available, or obtain coverage referenced in Section 2.5, to provide Contracted Services on an Emergent Care basis twenty-four (24) hours a day, seven (7) days a week.

2.4 **Office Availability/Access.** Provider shall maintain such offices, equipment, patient service personnel and allied health personnel as may be necessary to provide Contracted Services. Provider shall provide Contracted Services under this Amendment at Provider's offices during normal business hours, and shall be available, or obtain coverage referenced in Section 2.5

2.5 **Coverage** If a Provider Professional is absent from his or her practice from any reason, Provider shall secure appropriate coverage for the Provider Professional, and ensure that the covering professional is a Provider Professional and is otherwise compliant with the terms of this

2.6 **Notice of Adverse Action**. Provider shall provide written notice to UBH within five (5) calendar days of the occurrence of any of the following:

Any action taken to restrict, suspend or revoke Provider's or a Provider Professional's license or authorization to provide Contracted Services;

Any suit or arbitration action brought by a patient against Provider or a Provider Professional for malpractice. In addition, Provider shall send UBH a summary of the final disposition of such action;

Any misdemeanor conviction or felony information or indictment naming Provider or a Provider Professional. In addition, Provider shall send UBH a summary of the final disposition thereof;

Any disciplinary proceeding or action naming Provider or a Provider Professional before an administrative agency in any state. In addition, Provider shall send UBH a summary of the final disposition thereof;

Any cancellation or material modification of the professional liability insurance required to be carried by Provider or a Provider Professional under the terms of this Amendment;

Any action taken to restrict, suspend or revoke Provider's or a Provider Professional's participation in Medicare, Medicaid or CHAMPUS, VA CCN or any succeeding program. In addition, Provider shall send UBH a summary of the final disposition thereof;

Any material Enrolled Eligible Veteran complaints against Provider or a Provider Professional; or

Any other event or situation that could materially affect Provider's ability to carry out Provider's duties and obligations under this Amendment.

2.7 **Non-Discrimination**. Provider shall not discriminate against any Enrolled Eligible Veteran in the provision of Contracted Services hereunder, whether on the basis of the Enrolled Eligible Veteran's coverage under the VA CCN, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, health status, source of payment, utilization of medical or mental health services, equipment, pharmaceuticals or supplies, or other unlawful basis including, without limitation, the filing by such Enrolled Eligible Veteran of any complaint, grievance or legal action against Provider or UBH. Provider will make reasonable accommodations for Enrolled Eligible Veteran with disabilities or handicaps, in accordance with all applicable law, including but not limited to, providing such auxiliary aides and services to Enrolled Eligible Veterans at the Provider's expense as are reasonable, necessary and appropriate for the proper rendering of Contracted Services.

2.8 **Clinical Quality Monitoring Plan**. Provider will comply with all provisions of the clinical quality monitoring plan, including the provision of medical records and other documentation, and those provisions of VA CCN Requirements that state Provider will cooperate fully with a designated utilization and clinical quality monitoring organization, will agree to follow all quality assurance, utilization management, and patient referral procedures established under VA CCN Requirements, will make available medical records or other pertinent records to designated Veteran's Administration utilization management or quality monitoring contractors, and will authorize the release of information as required by UBH for such quality assurance and utilization management activities. Provider further authorizes UBH to release all review data obtained through medical record and other document audits required by the VA or any peer reviewer.

2.9 **Prior Authorization**. All services other than Emergent Care require a Prior Authorization from the VA. If a Prior Authorization from the VA is not obtained in accordance with VA CCN Requirements, Provider's payment will not be reimbursed, and Provider shall not bill the Enrolled Eligible Veteran. Prior Authorization is not a guarantee of payment; payment determinations are made after the claim is submitted for payment, based on the factors set forth in this Amendment and the Provider Manual.

The preferred method of submitting Prior Authorization requests is in electronic format. If Provider has the capability to submit EDI 278 transactions, Provider will submit Prior Authorization requests via Direct Messaging, eHealth Exchange secure online file exchange, secure email, secure fax, or telephone.

2.10 **Referrals**. All services require an Approved Referral from the VA. The provision of services must be limited to what is set forth in the Approved Referral, which is only valid for the services, time and treatment period specified. Services not included in the Approved Referral and any applicable extension of time and treatment period must be requested by the Provider as a new Approved Referral request.

Where an Enrolled Eligible Veteran self-presents for Emergent Care to an in-network emergency department without an Approved Referral, Provider must both notify the VA and request retroactive Approved Referral from

the VA within seventy -two (72) hours of the Enrolled Eligible Veteran self-presenting to the in-network emergency department.

2.11 Medical Documentation. The Provider must deliver, directly to the VA or the referring provider, medical documentation in a secure electronic format or otherwise as defined in the Provider Manual, and include, at a minimum, the data elements described in the Provider Manual.

2.12 Quality Management and Improvement Program. Provider will participate in, cooperate with and comply with all quality management and improvement program requirements and all decisions rendered by UBH in connection with the quality management and improvement program. Provider also will provide, within ten (10) days of receipt of written or electronic notice, all medical records, review data and other information as may be required or requested under the quality management and improvement program. Records required or requested by UBH under the quality management and improvement program for VA CCN are not subject to reimbursement by UBH.

2.13 Professional Liability Insurance.

a. This a non- personal services contract, as defined in Federal Acquisition Regulation (FAR) 37.101, under which the professional services rendered by the Provider are rendered in its capacity as an independent contractor. The Government may evaluate the quality of professional and administrative services provided but retains no control over professional aspects of the services rendered, including by example, a Provider's professional medical judgment, diagnosis, or specific medical treatments. Each Provider shall be liable for his or her liability-producing acts or omissions. The Provider shall maintain during the term of this Amendment, professional liability insurance issued by a responsible insurance carrier of not less than the following amount(s) per specialty per occurrence: $1,000,000 per occurrence; $3,000,000 aggregate. However, if the Provider is an entity or a subdivision of a State that either provides for self-insurance or limits the liability or the amount of insurance purchased by State entities, then the insurance requirement of this Amendment shall be fulfilled by incorporating the provisions of the applicable State law.

b. Provider's liability insurance shall be of the types and in the amounts set forth in paragraph (a), and may be of the types and amounts as specified by applicable State law. In lieu of purchasing the required insurance coverage, Provider may self-insure its medical malpractice and/or professional liability, as well as its commercial general liability coverage.

c. Unskilled or non-clinical Providers, e.g. Tai Chi instructors, massage therapists, etc. are only required to maintain insurance coverage consistent with the types and limits commonly necessary for their scope of practice, as determined by UBH and the VA.

d. Provider will, upon request, furnish evidence to UBH of its insurability, as required in this section, or the provisions of State law as to self-insurance, or limitations on liability or insurance. Provider shall also provide Certificates of Insurance or insurance policies evidencing the required insurance coverage and an endorsement stating that any cancellation or material change adversely affecting the Government's interest shall not be effective until 30 days after the insurer or the Provider gives written notice to UBH.

e. Provider will notify UBH if it changes insurance providers during the term this Amendment. The notification shall provide evidence that the Provider will meet all the requirements of this section, including those concerning liability insurance and endorsements. These requirements may be met either under the new policy, or a combination of old and new policies, if applicable.

f. If Provider uses the self-insurance option described in this Section, Provider will provide to UBH, prior to Effective Date, a statement verified by an independent auditor or actuary that its reserve funding levels and process of funding appears to be adequate to meet the requirements of this section and fairly represents the financial condition of the fund. Provider will provide a similar statement during the term of this Amendment upon UBH's request, which will be made no more frequently than annually or as otherwise specified by the VA. Provider will ensure that its self-insurance fund complies with applicable laws and regulations.

2.14 **Listing of Provider**. UBH and its designees may list the name, address, telephone number and other factual information of Provider, in UBH's provider directory and/or informational materials provided to the VA or otherwise developed by UBH as third party administrator for the VA . In no event shall Provider market or advertise the VA CCN without the prior written consent of UBH, except that Provider may make known the fact that it is a participating provider with UBH for the VA CCN.

2.15 **Identification Number/Payment of Taxes.** Provider shall notify UBH in writing, thirty (30) days in advance, of any changes to Provider's federal tax identification numbers or national provider identification numbers.

2.16 **Electronic Connectivity**. When made available by UBH, Provider will make reasonable commercial efforts to do business with UBH electronically. This includes, but is not limited to, checking eligibility status, claims status, and submitting requests for claims adjustments, referrals, prior authorizations, and claims submission, as well as for additional functionalities after UBH informs Provider that such functionalities have become available. Providers who do not do business with UBH electronically may be moved to the end of referral and provider directory search lists.

ARTICLE III
SUBMISSION, PROCESSING AND PAYMENT OF CLAIMS

3.1 **Submission of Claims**. Provider shall, when possible, submit all claims electronically to UBH. Claims shall be submitted as complete, accurate Clean Claims in a format approved by UBH for Contracted Services rendered to an Enrolled Eligible Veteran.

Claims must be submitted within one hundred eighty (180) days after the date of service or date of discharge. Claims received by UBH beyond the timely filing periods specified in this section will be denied. Provider shall not seek or accept payment from the Enrolled Eligible Veteran in the event UBH, as a third party administrator for the VA, does not pay Provider for a claim not submitted in a timely manner. Additionally, electronic claims must comply with standardized electronic transactions and code sets as required pursuant to the Health Insurance Portability and Accountability Act ("HIPAA").

Provider will comply with VA CCN Requirements when billing and collecting and/or seeking administrative review of payment for Contracted Services rendered pursuant to this Amendment.

3.2 **Reimbursement.** UBH, as a third party administrator for the VA, will pay claims for Contracted Services as further described in the applicable Payment Appendix to this Amendment, and in accordance with the VA CCN Requirements. Provider agrees to accept the Reimbursement Rates as payment in full for Covered Services. In no event will reimbursement for Covered Services exceed the maximum allowed by the VA CCN Requirements.

3.3 **No Surcharges**. Provider shall not charge the Enrolled Eligible Veteran any fees or surcharges for Covered Services rendered pursuant to this Amendment, or any membership fee or other fee as a prerequisite for accepting an Enrolled Eligible Veteran as a patient. In addition, Provider shall not collect sales or use tax from Enrolled Eligible Veterans for the sale or delivery of Covered Services. If UBH receives notice of any additional charge, Provider shall fully cooperate with UBH to investigate such allegations, and shall promptly refund any payment deemed improper to the party who made the payment.

3.4 **Enrolled Eligible Veteran Hold Harmless**. Provider acknowledges that Enrolled Eligible Veterans do not have financial responsibility for any Covered Services. Provider agrees that in no event, including, but not limited to, non-payment by UBH, as a third party administrator for the VA, the insolvency of UBH, or breach of this Amendment, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Enrolled Eligible Veteran or persons other than VA or UBH, as a third party administrator for the VA, for Covered Services. In no event may Provider bill, charge, collect a

deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against an Enrolled Eligible Veteran for any services denied for failure of Provider to obtain an Approved Referral or any required Prior Authorizations from VA. Enrolled Eligible Veterans must always be held harmless in cases where the Provider fails to submit a claim in accordance with the VA CCN Requirements, delivers healthcare services outside of the validity period or outside the scope of the Approved Referral, or otherwise fails to comply with the VA CCN Requirements. This provision shall survive termination of this Amendment, regardless of the cause giving rise to termination. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Enrolled Eligible Veteran or persons acting on their behalf.

3.5 **Other Health Insurance.** Provider shall adhere to the Other Health Insurance policies and procedures set forth in the VA CCN Requirements.

3.6 **Third Party Recoveries**. If UBH, as a third party administrator for the VA, has compensated Provider for Covered Services, UBH retains the right to recover from applicable third parties responsible for payment for services rendered to an Enrolled Eligible Veteran and to retain all such recoveries. Provider will provide UBH with such information as UBH may require in order to pursue recoveries from such third party sources, and to promptly remit to UBH any monies Provider may receive from or with respect to such sources of recovery.

3.7 **Correction of Claims Payments**. UBH, as a third party administrator for the VA, may recover from Provider amounts owed to UBH under this Amendment.

Where a claim is denied partially or in its entirety, Provider must file a written reconsideration request in accordance with the VA CCN Requirements within ninety (90) calendar days from the date of denial. Where a claim has not been denied partially or in its entirety, but the Provider believes the claim has been incorrectly paid, the Provider must seek correction of a given claim payment by giving written notice to UBH within twelve (12) months after the claim was initially processed.

Provider's failure to comply with the foregoing or any other VA CCN Requirements pertaining to timely filing, reconsideration requests or correction of claim payments will waive any right by Provider to subsequently seek such payment or correction of payment under this Amendment, or through dispute resolution or in any other forum.

UBH shall have the right, upon written or electronic notice to Provider, to offset overpayments and other amounts Provider owes UBH under this Amendment against future payments otherwise due to Provider

3.8 **VA CCN Contract Phase-Out**. Provider will use reasonable commercial efforts to submit all VA CCN claims within thirty (30) days from date of service or discharge during the phase-out period of UBH's VA CCN contract with the UBH States Government.

ARTICLE IV.
TERM AND TERMINATION

4.1 This Amendment shall take effect on the Amendment Effective Date and shall continue until one of the following occurs:

a)The parties mutually agree in writing to terminate this Amendment;
b)Either party terminates the Amendment by providing one-hundred and eighty (180) days prior written notice to the other party;
c)The Prime Contract expires or is terminated;
d)A material breach of this Amendment by either party upon sixty (60) days written notice, except that such termination will not take effect if the breach is cured within forty-five (45) days after notice of breach.

4.2 **Reimbursement of Services after Termination**. UBH will not reimburse the Provider for any Covered Services provided to an Enrolled Eligible Veteran after this Amendment terminates.

4.3 **Enrolled Eligible Veteran Notification**. Provider shall notify any Enrolled Eligible Veteran seeking professional services from Provider after the date of termination of this Amendment that the Provider is no longer a participating provider with UBH for VA CCN. The parties agree to cooperate in good faith and without disparagement in connection with information supplied to Enrolled Eligible Veteran in connection with any termination of this Amendment.

ARTICLE V.
MISCELLANEOUS PROVISIONS

5.1 **Governing Law**. This Amendment will be governed by and construed in accordance with VA CCN Requirements and the laws of the state(s) in which Provider renders Contracted Services (except where preempted by Federal law), and any other applicable law. The parties agree to comply with all applicable laws, rules and regulations regarding the performance of their obligations under this Amendment. UBH reserves the right to unilaterally amend, revise, or supplement this Amendment with written or electronic notice to Provider where necessary to maintain compliance with VA direction, the Prime Contract, and/or any applicable laws, rules, or regulations.

5.2 **Supplemental Terms and Conditions**. This Amendment is subject to the supplemental terms and conditions specified in Exhibit A.

5.3 **Appendix 2 of the Agreement**. With this Amendment, the VA Benefit Plan is added to Section 1 of Appendix 2 of the Agreement.

5.4 **Conflict of Provisions**. The Provider Manual controls in the event of any material conflict with this Amendment. Applicable statutes or regulations will control in the event of any material conflict with the terms of this Amendment or the Provider Manual.

List of Exhibits:

Exhibit A: Payment Appendix
Exhibit B: Federal Acquisition Regulation (FAR) and Veterans Affairs Acquisition Regulation (VAAR)
Exhibit A

Payment Appendix – Veterans Affairs

APPLICABILITY

This Payment Appendix applies to Covered Services rendered to a Veteran enrolled in a Veterans Affairs Benefit Program.

SECTION 1
DEFINITIONS

Unless otherwise defined in this section 1, capitalized terms used in this Payment Appendix have the meanings assigned to them in this Agreement.

CMS Fee Amount: The fee amount specified in the current year Medicare fee schedule published by the Centers for Medicare and Medicaid Services for the Carrier Locality in which services were provided.

Customary Charge: The fee for health care services or supplies charged by Provider that does not exceed the fee Provider would ordinarily charge another person regardless of whether the person is a Veteran.

Provider: The person or practice that is the contracted party to the Provider participation agreement to which this appendix is attached.

VA Fee Schedule: The fee schedule published by the United States Department of Veterans Affairs pursuant to 38 CFR 17.55 or 17.56, as applicable.

SECTION 2
CONTRACT RATES FOR COVERED SERVICES

2.1 Contract Rates. The contract rates for Covered Services are the lesser of Customary Charges and the applicable contract rate as follows:

(i) Except as otherwise provided in this Section, the contract rate for Covered Services is 100% of the CMS Fee Amount;

(ii) For Covered Services that are not covered by the Medicare program or for which the Medicare program does not have local pricing, the contract rate is the amount specified in the applicable VA Fee Schedule.

(iii) For Covered Services that are not covered by the Medicare program or for which the Medicare program does not have local pricing and for which the VA Fee Schedule does not have pricing, the contract rate is 100% of your Customary Charges for Covered Services.

(iv) For Covered Services which are marked as approved under Mill Bill, the Veterans Millennial Health Care Act, the contract rate is the lesser of the amount for which the veteran is responsible or 70% of the CMS Fee Schedule.

SECTION 3
MISCELLANEOUS

3.1 Billing and Filing of Claims. Provider will submit claims using a CMS 1500, its successor form or its electronic equivalent as prescribed by Optum. All claims submitted under this Payment Appendix must use CPT Codes, HCPCS Codes, ICD Codes or its successor and other codes in compliance with HIPAA standard data set requirements. Claims submitted without HIPAA standard data set requirements may be denied.

3.2 Routine Maintenance. Optum routinely updates the fee schedule in response to changes published by the Fee Source, such as fee amount changes. Optum will use reasonable commercial efforts to implement the fee schedule changes in its systems within 90 days after final publication. These changes will be effective in our system on the effective date of the change provided by the Fee Source. However, claims already processed prior to the change being implemented by Optum will not be reprocessed unless otherwise required by the U.S. Department of Veterans Affairs.

Optum also routinely updates the fee schedule in response to coding changes as described in this Agreement. When implementing coding updates, Optum will apply the same percentage(s) as set forth above in section 1 and the then current value of the published code to determine the contract rate. Optum will use reasonable commercial efforts to implement such changes within 90 days from the date of publication. Claims already processed prior to the change being implemented by Optum will not be reprocessed unless otherwise required by the U.S. Department of Veterans Affairs.

3.3 Payment Code Updates. Optum will update CPT codes, HCPCS codes, ICD codes or successor version and/or revenue codes according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD manual which is issued by the U.S. Department of Health and Human Services and (d) the latest revenue code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Payment Appendix, the contract rate for a new, replacement, or

modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified. Optum will not generally notify Provider of these code updates.

Exhibit B:

FEDERAL ACQUISITION REGULATION (FAR) AND VETERANS AFFAIRS ACQUISITION REGULATION (VAAR)

FLOWDOWN PROVISIONS FOR FIXED PRICE SUBCONTRACTS/PURCHASE ORDERS FOR COMMERCIAL ITEMS OR SERVICES UNDER A UBH STATES DEPARTMENT OF VETERANS AFFAIRS PRIME CONTRACT

A. INCORPORATION OF FAR AND VAAR CLAUSES

The FAR and VAAR clauses referenced below are incorporated herein by reference, with the same force and effect as if they were given in full text, and are applicable, including any notes following the clause citation, to this Agreement. If the date or substance of any of the clauses listed below is different from the date or substance of the clause actually incorporated in the Prime Contract referenced by number herein, the date or substance of the clause incorporated by said Prime Contract shall apply instead. The Contracts Disputes Act shall have no application to this Agreement. Any reference to a "Disputes" clause shall mean the "Disputes" clause of this Agreement.

B. GOVERNMENT SUBCONTRACT

(1) This Agreement is entered into by the parties in support of a UBH States Government contract.

(2) As used in the FAR and VAAR clauses referenced below and otherwise in this Agreement:

(a) "Commercial Item" means a commercial item as defined in FAR 2.101.

(b) "Contract" means this Agreement.

(c) "Contracting Officer" shall mean the UBH States Government Contracting Officer for OPTUM's government Prime Contract under which this Agreement is entered.

(d) "Contractor" and "Offeror" means the VENDOR, which is the party identified on the face of this Agreement with whom OPTUM is contracting, acting as the immediate subcontractor to OPTUM.

(e) "Prime Contract" means the contract between OPTUM and the UBH States Government or between OPTUM and its higher-tier contractor who has a contract with the UBH States Government.

(f) "Subcontract" means any contract placed by VENDOR or lower-tier subcontractors under this Agreement.

C. NOTES

The following notes apply to the clauses incorporated by reference below only when specified in the parenthetical phrase following the clause title and date.

(1) Substitute "OPTUM" for "Government" or "UBH States" throughout this clause.

(2) Substitute "OPTUM Subcontract Administrator" for "Contracting Officer", "Administrative Contracting Officer", “CO” and "ACO" throughout this clause.

(3) Insert "and OPTUM" after "Government" throughout this clause.

(4) Insert "or OPTUM" after "Government" throughout this clause.

(5) Communication/notification required under this clause from/to VENDOR to/from the Contracting Officer shall be through OPTUM.

(6) Insert "and OPTUM Subcontract Administrator" after "Contracting Officer", throughout the clause.

(7) Insert "or OPTUM Subcontract Administrator" after "Contracting Officer", throughout the clause.

(8) If VENDOR is an international contractor, this clause applies to this Agreement only if Work under the Agreement will be performed in the UBH States or VENDOR is recruiting employees in the UBH States to Work on the Agreement.

D. AMENDMENTS REQUIRED BY PRIME CONTRACT

VENDOR agrees that upon the request of OPTUM it will negotiate in good faith with OPTUM relative to amendments to this Agreement to incorporate additional provisions herein or to change provisions hereof, as OPTUM may reasonably deem necessary in order to comply with the terms of the applicable Prime Contract or with amendments to such Prime Contract. If any such amendment to this Agreement causes an increase or decrease in the cost of, or the time required for, performance of any part of the Work under this Agreement, an equitable adjustment shall be made pursuant to the "Changes" clause of this Agreement.

E. PRESERVATION OF THE GOVERNMENT'S RIGHTS

If OPTUM furnishes designs, drawings, special tooling, equipment, engineering data, or other technical or proprietary information (Furnished Items) which the UBH States Government owns or has the right to authorize the use of, nothing herein shall be construed to mean that OPTUM, acting on its own behalf, may modify or limit any rights the UBH States Government may have to authorize VENDOR's use of such Furnished Items in support of other UBH States Government prime contracts.

CONTRACT CLAUSES

C.1 52.212-4 CONTRACT TERMS AND CONDITIONS—COMMERCIAL ITEMS (MAY 2015) (3)

1. The Following Paragraphs of this clause do not apply to this Agreement
2. (b) Assignment
3. (d) Disputes
4. (g) Invoice
5. (I) Payment
6. (s) Order of Precedence

(a) *Inspection/Acceptance.* The Contractor shall only tender for acceptance those items that conform to the requirements of this contract. The Government reserves the right to inspect or test any supplies or services that have been tendered for acceptance. The Government may require repair or replacement of nonconforming supplies or reperformance of nonconforming services at no increase in contract price. If repair/replacement or reperformance will not correct the defects or is not possible, the Government may seek an equitable price reduction or adequate consideration for acceptance of nonconforming supplies or services. The Government must exercise its post-acceptance rights—

(1) Within a reasonable time after the defect was discovered or should have been discovered; and

(2) Before any substantial change occurs in the condition of the item, unless the change is due to the defect in the item.

(b) *Assignment.* The Contractor or its assignee may assign its rights to receive payment due as a result of performance of this contract to a bank, trust company, or other financing institution, including any Federal lending agency in accordance with the Assignment of Claims Act (31 U.S.C. 3727). However, when a third party makes payment (e.g., use of the Government wide commercial purchase card), the Contractor may not assign its rights to receive payment under this contract.

(c) *Changes.* Changes in the terms and conditions of this contract may be made only by written agreement of the parties.
(d) *Disputes*. This contract is subject to 41 U.S.C. chapter 71, Contract Disputes. Failure of the parties to this contract to reach agreement on any request for equitable adjustment, claim, appeal or action arising under or relating to this contract shall be a dispute to be resolved in accordance with the clause at FAR 52.233-1, Disputes, which is incorporated herein by reference. The Contractor shall proceed diligently with performance of this contract, pending final resolution of any dispute arising under the contract.
(e) *Definitions.* The clause at FAR 52.202-1, Definitions, is incorporated herein by reference.
(f) *Excusable delays.* The Contractor shall be liable for default unless nonperformance is caused by an occurrence beyond the reasonable control of the Contractor and without its fault or negligence such as, acts of God or the public enemy, acts of the Government in either its sovereign or contractual capacity, fires, floods, epidemics, quarantine restrictions, strikes, unusually severe weather, and delays of common carriers. The Contractor shall notify the Contracting Officer in writing as soon as it is reasonably possible after the commencement of any excusable delay, setting forth the full particulars in connection therewith, shall remedy such occurrence with all reasonable dispatch, and shall promptly give written notice to the Contracting Officer of the cessation of such occurrence.
(g) Invoice.

(1) The Contractor shall submit an original invoice and three copies (or electronic invoice, if authorized) to the address designated in the contract to receive invoices. An invoice must include—
(i) Name and address of the Contractor;
(ii) Invoice date and number;
(iii) Contract number, contract line item number and, if applicable, the order number;
(iv) Description, quantity, unit of measure, unit price and extended price of the items delivered;
(v) Shipping number and date of shipment, including the bill of lading number and weight of shipment if shipped on Government bill of lading;
(vi) Terms of any discount for prompt payment offered;
(vii) Name and address of official to whom payment is to be sent;
(viii) Name, title, and phone number of person to notify in event of defective invoice; and
(ix) Taxpayer Identification Number (TIN). The Contractor shall include its TIN on the invoice only if required elsewhere in this contract.
(x) Electronic funds transfer (EFT) banking information.
(A) The Contractor shall include EFT banking information on the invoice only if required elsewhere in this contract.
(B) If EFT banking information is not required to be on the invoice, in order for the invoice to be a proper invoice, the Contractor shall have submitted correct EFT banking information in accordance with the applicable solicitation provision, contract clause (e.g., 52.232-33, Payment by Electronic Funds Transfer—System for Award Management, or 52.232-34, Payment by Electronic Funds Transfer—Other Than System for Award Management), or applicable agency procedures.
(C) EFT banking information is not required if the Government waived the requirement to pay by EFT.
(2) Invoices will be handled in accordance with the Prompt Payment Act (31 U.S.C. 3903) and Office of Management and Budget (OMB) prompt payment regulations at 5 CFR part 1315.
(h) *Patent indemnity.* The Contractor shall indemnify the Government and its officers, employees and agents against liability, including costs, for actual or alleged direct or contributory infringement of, or inducement to infringe, any UBH States or foreign patent, trademark or copyright, arising out of the performance of this contract, provided the Contractor is reasonably notified of such claims and proceedings.
(i) Payment.—
(1) *Items accepted.* Payment shall be made for items accepted by the Government that have been delivered to the delivery destinations set forth in this contract.
(2) *Prompt payment.* The Government will make payment in accordance with the Prompt Payment Act (31 U.S.C. 3903) and prompt payment regulations at 5 CFR part 1315.
(3) *Electronic Funds Transfer (EFT).* If the Government makes payment by EFT, see 52.212-5(b) for the appropriate EFT clause.

(4) *Discount.* In connection with any discount offered for early payment, time shall be computed from the date of the invoice. For the purpose of computing the discount earned, payment shall be considered to have been made on the date which appears on the payment check or the specified payment date if an electronic funds transfer payment is made.

(5) *Overpayments.* If the Contractor becomes aware of a duplicate contract financing or invoice payment or that the Government has otherwise overpaid on a contract financing or invoice payment, the Contractor shall—

(i) Remit the overpayment amount to the payment office cited in the contract along with a description of the overpayment including the—

(A) Circumstances of the overpayment (e.g., duplicate payment, erroneous payment, liquidation errors, date(s) of overpayment);

(B) Affected contract number and delivery order number, if applicable;

(C) Affected contract line item or subline item, if applicable; and

(D) Contractor point of contact.

(ii) Provide a copy of the remittance and supporting documentation to the Contracting Officer.

(6) *Interest*.

(i) All amounts that become payable by the Contractor to the Government under this contract shall bear simple interest from the date due until paid unless paid within 30 days of becoming due. The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in 41 U.S.C. 7109, which is applicable to the period in which the amount becomes due, as provided in (i)(6)(v) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid.

(ii) The Government may issue a demand for payment to the Contractor upon finding a debt is due under the contract.

(iii) *Final decisions.* The Contracting Officer will issue a final decision as required by 33.211 if—

(A) The Contracting Officer and the Contractor are unable to reach agreement on the existence or amount of a debt within 30 days;

(B) The Contractor fails to liquidate a debt previously demanded by the Contracting Officer within the timeline specified in the demand for payment unless the amounts were not repaid because the Contractor has requested an installment payment agreement; or

(C) The Contractor requests a deferment of collection on a debt previously demanded by the Contracting Officer (see 32.607-2).

(iv) If a demand for payment was previously issued for the debt, the demand for payment included in the final decision shall identify the same due date as the original demand for payment.

(v) Amounts shall be due at the earliest of the following dates:

(A) The date fixed under this contract.

(B) The date of the first written demand for payment, including any demand for payment resulting from a default termination.

(vi) The interest charge shall be computed for the actual number of calendar days involved beginning on the due date and ending on—

(A) The date on which the designated office receives payment from the Contractor;

(B) The date of issuance of a Government check to the Contractor from which an amount otherwise payable has been withheld as a credit against the contract debt; or

(C) The date on which an amount withheld and applied to the contract debt would otherwise have become payable to the Contractor.

(vii) The interest charge made under this clause may be reduced under the procedures prescribed in 32.608-2 of the Federal Acquisition Regulation in effect on the date of this contract.

(j) *Risk of loss.* Unless the contract specifically provides otherwise, risk of loss or damage to the supplies provided under this contract shall remain with the Contractor until, and shall pass to the Government upon:

(1) Delivery of the supplies to a carrier, if transportation is f.o.b. origin; or

(2) Delivery of the supplies to the Government at the destination specified in the contract, if transportation is f.o.b. destination.

(k) *Taxes.* The contract price includes all applicable Federal, State, and local taxes and duties.

(l) *Termination for the Government's convenience.* The Government reserves the right to terminate this contract, or any part hereof, for its sole convenience. In the event of such termination, the Contractor shall immediately stop all work hereunder and shall immediately cause any and all of its suppliers and subcontractors to cease work. Subject to the terms of this contract, the Contractor shall be paid a percentage of the contract price reflecting the percentage of the work performed prior to the notice of termination, plus reasonable charges the Contractor can demonstrate to the satisfaction of the Government using its standard record keeping system, have resulted from the termination. The Contractor shall not be required to comply with the cost accounting standards or contract cost principles for this purpose. This paragraph does not give the Government any right to audit the Contractor's records. The Contractor shall not be paid for any work performed or costs incurred which reasonably could have been avoided.

(m) *Termination for cause.* The Government may terminate this contract, or any part hereof, for cause in the event of any default by the Contractor, or if the Contractor fails to comply with any contract terms and conditions, or fails to provide the Government, upon request, with adequate assurances of future performance. In the event of termination for cause, the Government shall not be liable to the Contractor for any amount for supplies or services not accepted, and the Contractor shall be liable to the Government for any and all rights and remedies provided by law. If it is determined that the Government improperly terminated this contract for default, such termination shall be deemed a termination for convenience.

(n) *Title.* Unless specified elsewhere in this contract, title to items furnished under this contract shall pass to the Government upon acceptance, regardless of when or where the Government takes physical possession.

(o) *Warranty.* The Contractor warrants and implies that the items delivered hereunder are merchantable and fit for use for the particular purpose described in this contract.

(p) *Limitation of liability.* Except as otherwise provided by an express warranty, the Contractor will not be liable to the Government for consequential damages resulting from any defect or deficiencies in accepted items.

(q) *Other compliances.* The Contractor shall comply with all applicable Federal, State and local laws, executive orders, rules and regulations applicable to its performance under this contract.

(r) Compliance with laws unique to Government contracts. The Contractor agrees to comply with 31 U.S.C. 1352 relating to limitations on the use of appropriated funds to influence certain Federal contracts; 18 U.S.C. 431 relating to officials not to benefit; 40 U.S.C. chapter 37, Contract Work Hours and Safety Standards; 41 U.S.C. chapter 87, Kickbacks; 41 U.S.C. 4712 and 10 U.S.C. 2409 relating to whistleblower protections; 49 U.S.C. 40118, Fly American; and 41 U.S.C. chapter 21 relating to procurement integrity.

(s) *Order of precedence.* Any inconsistencies in this solicitation or contract shall be resolved by giving precedence in the following order:

(1) The schedule of supplies/services.

(2) The Assignments, Disputes, Payments, Invoice, Other Compliances, Compliance with Laws Unique to Government Contracts, and Unauthorized Obligations paragraphs of this clause;

(3) The clause at 52.212-5.

(4) Addenda to this solicitation or contract, including any license agreements for computer software.

(5) Solicitation provisions if this is a solicitation.

(6) Other paragraphs of this clause.

(7) The Standard Form 1449.

(8) Other documents, exhibits, and attachments

(9) The specification.

(t) *System for Award Management (SAM).*

(1) Unless exempted by an addendum to this contract, the Contractor is responsible during performance and through final payment of any contract for the accuracy and completeness of the data within the SAM database, and for any liability resulting from the Government's reliance on inaccurate or incomplete data. To remain registered in the SAM database after the initial registration, the Contractor is required to review and update on an annual basis from the date of initial registration or subsequent updates its information in the SAM database to ensure it is current, accurate and complete. Updating information in the SAM does not alter the terms and conditions of this contract and is not a substitute for a properly executed contractual document.

(2)(i) If a Contractor has legally changed its business name, "doing business as" name, or division name (whichever is shown on the contract), or has transferred the assets used in performing the contract, but has not completed the necessary requirements regarding novation and change-of-name agreements in FAR

subpart 42.12, the Contractor shall provide the responsible Contracting Officer a minimum of one business day's written notification of its intention to (A) change the name in the SAM database; (B) comply with the requirements of subpart 42.12; and (C) agree in writing to the timeline and procedures specified by the responsible Contracting Officer. The Contractor must provide with the notification sufficient documentation to support the legally changed name.

(ii) If the Contractor fails to comply with the requirements of paragraph (t)(2)(i) of this clause, or fails to perform the agreement at paragraph (t)(2)(i)(C) of this clause, and, in the absence of a properly executed novation or change-of-name agreement, the SAM information that shows the Contractor to be other than the Contractor indicated in the contract will be considered to be incorrect information within the meaning of the "Suspension of Payment" paragraph of the electronic funds transfer (EFT) clause of this contract.

(3) The Contractor shall not change the name or address for EFT payments or manual payments, as appropriate, in the SAM record to reflect an assignee for the purpose of assignment of claims (see Subpart 32.8, Assignment of Claims). Assignees shall be separately registered in the SAM database. Information provided to the Contractor's SAM record that indicates payments, including those made by EFT, to an ultimate recipient other than that Contractor will be considered to be incorrect information within the meaning of the "Suspension of payment" paragraph of the EFT clause of this contract.

(4) Offerors and Contractors may obtain information on registration and annual confirmation requirements via SAM accessed through https://www.acquisition.gov.

(u) *Unauthorized Obligations*.

(1) Except as stated in paragraph (u)(2) of this clause, when any supply or service acquired under this contract is subject to any End User License Agreement (EULA), Terms of Service (TOS), or similar legal instrument or agreement, that includes any clause requiring the Government to indemnify the Contractor or any person or entity for damages, costs, fees, or any other loss or liability that would create an Anti- Deficiency Act violation (31 U.S.C. 1341), the following shall govern:

(i) Any such clause is unenforceable against the Government.

(ii) Neither the Government nor any Government authorized end user shall be deemed to have agreed to such clause by virtue of it appearing in the EULA, TOS, or similar legal instrument or agreement. If the EULA, TOS, or similar legal instrument or agreement is invoked through an “I agree” click box or other comparable mechanism (e.g., “click-wrap” or “browse-wrap” agreements), execution does not bind the Government or any Government authorized end user to such clause.

(iii) Any such clause is deemed to be stricken from the EULA, TOS, or similar legal instrument or agreement.

(2) Paragraph (u)(1) of this clause does not apply to indemnification by the Government that is expressly authorized by statute and specifically authorized under applicable agency regulations and procedures.

(v) *Incorporation by reference*. The Contractor’s representations and certifications, including those completed electronically via the System for Award Management (SAM), are incorporated by reference into the contract.

(End of Clause)

ADDENDUM to FAR 52.212-4 CONTRACT TERMS AND CONDITIONS—COMMERCIAL ITEMS

Clauses that are incorporated by reference (by Citation Number, Title, and Date), have the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make the full text available.
The following clauses are incorporated into 52.212-4 as an addendum to this contract:

C.2 52.252-2 CLAUSES INCORPORATED BY REFERENCE (FEB 1998)
This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make the full text available. Also, the full text of a clause may be accessed electronically at:

http://www.acquisition.gov/far/index.html
http://www.va.gov/oal/library/vaar/

(End of Clause)

FAR Number	Title	Date
52.204-9	PERSONAL IDENTITY VERIFICATION OF CONTRACTOR PERSONNEL	JAN 2011 (2)
52.204-13	SYSTEM FOR AWARD MANAGEMENT MAINTENANCE	JUL 2013
52.204-18	COMMERCIAL AND GOVERNMENT ENTITY CODE MAINTENANCE	JUL 2016
52.204-21	BASIC SAFEGUARDING OF COVERED CONTRACTOR INFORMATION SYSTEMS	JUN 2016
52.224-1	PRIVACY ACT NOTIFICATION	APR 1984
52.224-2	PRIVACY ACT	APR 1984
52.227-14	RIGHTS IN DATA—GENERAL	MAY 2014(5)
52.227-15	STATEMENTS OF LIMITED RIGHTS DATA AND RESTRICTED COMPUTER SOFTWARE	DEC 2007
52.227-16	ADDITIONAL DATA REQUIREMENTS	JUN 1987
52.232-18	AVAILABILITY OF FUNDS	APR 1984
52.232-40	PROVIDING ACCELERATED PAYMENTS TO SMALL BUSINESS SUBCONTRACTORS	DEC 2013(1)
52.237-3	CONTINUITY OF SERVICES	JAN 1991(2)

C.3 52.203-99 PROHIBITION ON CONTRACTING WITH ENTITIES THAT REQUIRE CERTAIN INTERNAL CONFIDENTIALITY AGREEMENTS (DEVIATION) (FEB 2015)

(a) The Contractor shall not require employees or contractors seeking to report fraud, waste, or abuse to sign or comply with internal confidentiality agreements or statements prohibiting or otherwise restricting such employees or subcontractors from lawfully reporting such waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information.

(b) The contractor shall notify employees that the prohibitions and restrictions of any internal confidentiality agreements covered by this clause are no longer in effect.

(c) The prohibition in paragraph (a) of this clause does not contravene requirements applicable to Standard Form 312, Form 4414, or any other form issued by a Federal department or agency governing the nondisclosure of classified information.

(d)(1) In accordance with section 743 of Division E, Title VII, of the Consolidated and Further Continuing Resolution Appropriations Act, 2015 (Pub. L. 113-235), use of funds appropriated (or otherwise made available) under that or any other Act may be prohibited, if the Government determines that the Contractor is not in compliance with the provisions of this clause.

(2) The Government may seek any available remedies in the event the contractor fails to comply with the provisions of this clause.

(End of Clause)

C.4 52.203-17 CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (APR 2014)

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112–239) and FAR 3.908.

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold.

(End of Clause)

C.5 52.204-4 PRINTED OR COPIED DOUBLE-SIDED ON POSTCONSUMER FIBER CONTENT PAPER (MAY 2011)

(a) *Definitions.* As used in this clause—

"Postconsumer fiber" means— (1) Paper, paperboard, and fibrous materials from retail stores, office buildings, homes, and so forth, after they have passed through their end-usage as a consumer item, including: used corrugated boxes; old newspapers; old magazines; mixed waste paper; tabulating cards; and used cordage; or

(2) All paper, paperboard, and fibrous materials that enter and are collected from municipal solid waste; but not

(3) Fiber derived from printers' over-runs, converters' scrap, and over-issue publications.

(b) The Contractor is required to submit paper documents, such as offers, letters, or reports that are printed or copied double-sided on paper containing at least 30 percent postconsumer fiber, whenever practicable, when not using electronic commerce methods to submit information or data to the Government.

(End of Clause)

C.7 52.217-7 OPTION FOR INCREASED QUANTITY—SEPARATELY PRICED LINE ITEM (MAR 1989) (1)(2)

The Government may require the delivery of the numbered line item, identified in the Schedule as an option item, in the quantity and at the price stated in the Schedule. The Contracting Officer may exercise the option by written notice to the Contractor within any time prior to contract expiration, provided the contracting officer gives at least 5 days notice of the government's intent to exercise the optional task.

Additional Line Items Identified as Optional: Additional line items identified as options are referred to as optional tasks. The government may exercise optional tasks by written notice to Contractor provided that the government gives the Contractor a preliminary notice of its intent to exercise the task at least 5 days prior to the start date of the option task. Provided proper preliminary notice is given, the optional tasks may be exercised during the performance of any exercised term of the contract as long as sufficient time remains under the contract.

(End of Clause)

C.8 52.217-8 OPTION TO EXTEND SERVICES (NOV 1999)(2)

The Government may require continued performance of any services within the limits and at the rates specified in the contract. These rates may be adjusted only as a result of revisions to prevailing labor rates provided by the Secretary of Labor. The option provision may be exercised more than once, but the total extension of performance hereunder shall not exceed 6 months. The Contracting Officer may exercise the option by written notice to the Contractor within 30 days of contract expiration.

(End of Clause)

C.9 52.222-49 SERVICE CONTRACT LABOR STANDARDS—PLACE OF PERFORMANCE UNKNOWN (MAY 2014)(TAILORED) (5)

(a) This contract is subject to the Service Contract Labor Standards statute, and the place of performance was unknown when the solicitation was issued. In addition to places or areas identified in wage determinations, if any, attached to the solicitation, wage determinations have also been requested for the following: All places of performance for all employees subject to the Service Contract Act. The contractor is responsible for adhering to general wage determinations issued by the Department of Labor for all places or areas of performance. These determinations may be found at http://www.wdol.gov/ The Contracting Officer will request wage determinations not issued by the Department of Labor for additional places or areas of performance, if asked to do so in writing within 10 business days of request.

(b) Offerors who intend to perform in a place or area of performance for which a wage determination has not been attached or requested may nevertheless submit bids or proposals. However, a wage determination shall be requested and incorporated in the resultant contract retroactive to the date of contract award, and there shall be no adjustment in the contract price.

(End of Clause)

C.10 VAAR 852.203-70 COMMERCIAL ADVERTISING (JAN 2008)

The bidder or offeror agrees that if a contract is awarded to him/her, as a result of this solicitation, he/she will not advertise the award of the contract in his/her commercial advertising in such a manner as to state or imply that the Department of Veterans Affairs endorses a product, project or commercial line of endeavor.

(End of Clause)

C.11 VAAR 852.203-71 DISPLAY OF DEPARTMENT OF VETERAN AFFAIRS HOTLINE POSTER (DEC 1992)

(a) Except as provided in paragraph (c) below, the Contractor shall display prominently, in common work areas within business segments performing work under VA contracts, Department of Veterans Affairs Hotline posters prepared by the VA Office of Inspector General.

(b) Department of Veterans Affairs Hotline posters may be obtained from the VA Office of Inspector General (53E), P.O. Box 34647, Washington, DC 20043-4647.

(c) The Contractor need not comply with paragraph (a) above if the Contractor has established a mechanism, such as a hotline, by which employees may report suspected instances of improper conduct, and instructions that encourage employees to make such reports.

(End of Clause)

C.12 VAAR 852.215-71 EVALUATION FACTOR COMMITMENTS (DEC 2009)

The offeror agrees, if awarded a contract, to use the service-disabled veteran-owned small businesses or veteran-owned small businesses proposed as subcontractors in accordance with 852.215-70, Service- Disabled Veteran-Owned and Veteran-Owned Small Business Evaluation Factors, or to substitute one or more service-disabled veteran-owned small businesses or veteran-owned small businesses for subcontract work of the same or similar value.

(End of Clause)

C.13 VAAR 852.219-9 VA SMALL BUSINESS SUBCONTRACTING PLAN MINIMUM REQUIREMENTS (DEC 2009)

(a) This clause does not apply to small business concerns.

(b) If the offeror is required to submit an individual subcontracting plan, the minimum goals for award of subcontracts to service-disabled veteran-owned small business concerns and veteran-owned small business concerns shall be at least commensurate with the Department's annual service-disabled veteran- owned small business and veteran-owned small business prime contracting goals for the total dollars planned to be subcontracted.

(c) For a commercial plan, the minimum goals for award of subcontracts to service-disabled veteran- owned small business concerns and veteran-owned small businesses shall be at least commensurate with the Department's annual service-disabled veteran-owned small business and veteran-owned small business prime contracting goals for the total value of projected subcontracts to support the sales for the commercial plan.

(d) To be credited toward goal achievements, businesses must be verified as eligible in the Vendor Information Pages database. The contractor shall annually submit a listing of service-disabled veteran- owned small businesses and veteran-owned small businesses for which credit toward goal achievement is to be applied for the review of personnel in the Office of Small and Disadvantaged Business Utilization.

(e) The contractor may appeal any businesses determined not eligible for crediting toward goal achievements by following the procedures contained in 819.407.

(End of Clause)

C.14 VAAR 852.237-7 INDEMNIFICATION AND MEDICAL LIABILITY INSURANCE (JAN 2008)

(a) It is expressly agreed and understood that this is a non- personal services contract, as defined in Federal Acquisition Regulation (FAR) 37.101, under which the professional services rendered by the Contractor or its health-care providers are rendered in its capacity as an independent contractor. The Government may evaluate the quality of professional and administrative services provided but retains no control over professional aspects of the services rendered, including by example, the Contractor's or its health-care providers' professional medical judgment, diagnosis, or specific medical treatments. The Contractor and its health-care providers shall be liable for their liability-producing acts or omissions. The Contractor shall

maintain or require all health-care providers performing under this contract to maintain, during the term of this contract, professional liability insurance issued by a responsible insurance carrier of not less than the following amount(s) per specialty per occurrence: $1,000,000 per occurrence;

$3,000,000 aggregate. However, if the Contractor is an entity or a subdivision of a State that either provides for self-insurance or limits the liability or the amount of insurance purchased by State entities, then the insurance requirement of this contract shall be fulfilled by incorporating the provisions of the applicable State law.

* Amounts are listed below:

(b) An apparently successful offeror, upon request of the Contracting Officer, shall, prior to contract award, furnish evidence of the insurability of the offeror and/or of all health- care providers who will perform under this contract. The submission shall provide evidence of insurability concerning the medical liability insurance required by paragraph (a) of this clause or the provisions of State law as to self- insurance, or limitations on liability or insurance.

(c) The Contractor shall, prior to commencement of services under the contract, provide to the Contracting Officer Certificates of Insurance or insurance policies evidencing the required insurance coverage and an endorsement stating that any cancellation or material change adversely affecting the Government's interest shall not be effective until 30 days after the insurer or the Contractor gives written notice to the Contracting Officer. Certificates or policies shall be provided for the Contractor and/or each health- care provider who will perform under this contract.

(d) The Contractor shall notify the Contracting Officer if it, or any of the health-care providers performing under this contract, change insurance providers during the performance period of this contract. The notification shall provide evidence that the Contractor and/or health-care providers will meet all the requirements of this clause, including those concerning liability insurance and endorsements. These requirements may be met either under the new policy, or a combination of old and new policies, if applicable.

(e) The Contractor shall insert the substance of this clause, including this paragraph (e), in all subcontracts for health-care services under this contract. The Contractor shall be responsible for compliance by any subcontractor or lower-tier subcontractor with the provisions set forth in paragraph (a) of this clause.

* Amounts from paragraph (a) above:

(End of Clause)

C.15 VAAR 852.237-70 CONTRACTOR RESPONSIBILITIES (APR 1984)

The contractor shall obtain all necessary licenses and/or permits required to perform this work. He/she shall take all reasonable precautions necessary to protect persons and property from injury or damage during the performance of this contract. He/she shall be responsible for any injury to himself/herself, his/her employees, as well as for any damage to personal or public property that occurs during the performance of this contract that is caused by his/her employees fault or negligence, and shall maintain personal liability and property damage insurance having coverage for a limit as required by the laws of ALL States and Territories where services are provided. Further, it is agreed that any negligence of the Government, its officers, agents, servants and employees, shall not be the responsibility of the contractor hereunder with the regard to any claims, loss, damage, injury, and liability resulting there from.

(End of Clause)

C.16 VAAR 852.271-70 NONDISCRIMINATION IN SERVICES PROVIDED TO BENEFICIARIES (JAN 2008)

The contractor agrees to provide all services specified in this contract for any person determined eligible by the Department of Veterans Affairs, regardless of the race, color, religion, sex, or national origin of the person for whom such services are ordered. The contractor further warrants that he/she will not resort to subcontracting as a means of circumventing this provision.

(End of Provision)

C.17 MANDATORY WRITTEN DISCLOSURES

Mandatory written disclosures required by FAR clause 52.203-13 to the Department of Veterans Affairs, Office of Inspector General (OIG) must be made electronically through the VA OIG Hotline at

http://www.va.gov/oig/contacts/hotline.asp and clicking on "FAR clause 52.203-13 Reporting." If you experience difficulty accessing the website, call the Hotline at 1-800-488-8244 for further instructions.

(End of Clause)

C.18 52.212-5 CONTRACT TERMS AND CONDITIONS REQUIRED TO IMPLEMENT STATUTES OR EXECUTIVE ORDERS—COMMERCIAL ITEMS (NOV 2016)

(a) The Contractor shall comply with the following Federal Acquisition Regulation (FAR) clauses, which are incorporated in this contract by reference, to implement provisions of law or Executive orders applicable to acquisitions of commercial items:

(1) 52.209-10, Prohibition on Contracting with Inverted Domestic Corporations (Nov 2015)

(2) RESERVED

(3) The Contractor shall comply with the FAR clauses in this paragraph (b) that the Contracting Officer has indicated as being incorporated in this contract by reference to implement provisions of law or Executive orders applicable to acquisitions of commercial items:

[X] (1) 52.203-6, Restrictions on Subcontractor Sales to the Government (Sept 2006), with Alternate I (Oct 1995) (41 U.S.C. 4704 and 10 U.S.C. 2402).

[X] (2) 52.203-13, Contractor Code of Business Ethics and Conduct (Oct 2015) (41 U.S.C. 3509)).

[X] (4) 52.204-10, Reporting Executive Compensation and First-Tier Subcontract Awards (Oct 2016) (Pub. L. 109-282) (31 U.S.C. 6101 note).

[X] (7) 52.204-15, Service Contract Reporting Requirements for Indefinite-Delivery Contracts (Oct 2016) (Pub. L. 111-117, section 743 of Div. C).

[X] (8) 52.209-6, Protecting the Government's Interest When Subcontracting with Contractors Debarred, Suspended, or Proposed for Debarment. (Oct 2015) (31 U.S.C. 6101 note).

[X] (9) 52.209-9, Updates of Publicly Available Information Regarding Responsibility Matters (Jul 2013) (41 U.S.C. 2313).

[X] (12)(i) 52.219-4, Notice of Price Evaluation Preference for HUBZone Small Business Concerns (Oct 2014) (if the offeror elects to waive the preference, it shall so indicate in its offer) (15 U.S.C. 657a).

[X] (16) 52.219-8, Utilization of Small Business Concerns (Nov 2016) (15 U.S.C. 637(d)(2) and (3)).

[X] (17)(i) 52.219-9, Small Business Subcontracting Plan (Nov 2016) (15 U.S.C. 637(d)(4)).

[X] (iii) Alternate II (Nov 2016) of 52.219-9.

[X] (20) 52.219-16, Liquidated Damages—Subcontracting Plan (Jan 1999) (15 U.S.C. 637(d)(4)(F)(i)).

[X] (22) 52.219-28, Post Award Small Business Program Rerepresentation (Jul 2013) (15 U.S.C. 632(a)(2)).

[X] (25) 52.222-3, Convict Labor (June 2003) (E.O. 11755).

[X] (27) 52.222-21, Prohibition of Segregated Facilities (Apr 2015).

[X] (28) 52.222-26, Equal Opportunity (Sept 2016) (E.O. 11246).

[X] (29) 52.222-35, Equal Opportunity for Veterans (Oct 2015)(38 U.S.C. 4212).

[X] (30) 52.222-36, Equal Opportunity for Workers with Disabilities (Jul 2014) (29 U.S.C. 793).

[X] (31) 52.222-37, Employment Reports on Veterans (Feb 2016) (38 U.S.C. 4212).

[X] (32) 52.222-40, Notification of Employee Rights Under the National Labor Relations Act (Dec 2010) (E.O. 13496).

[X] (33)(i) 52.222-50, Combating Trafficking in Persons (Mar 2015) (22 U.S.C. chapter 78 and E.O. 13627).

[X] (34) 52.222-54, Employment Eligibility Verification (Oct 2015). (Executive Order 12989). (Not applicable to the acquisition of commercially available off-the-shelf items or certain other types of commercial items as prescribed in 22.1803.)

[X] (42) 52.223-18, Encouraging Contractor Policies to Ban Text Messaging While Driving (Aug 2011) (E.O. 13513).

[X] (47) 52.225-5, Trade Agreements (Oct 2016) (19 U.S.C. 2501, et seq., 19 U.S.C. 3301 note).

[X] (48) 52.225-13, Restrictions on Certain Foreign Purchases (June 2008) (E.O.'s, proclamations, and statutes administered by the Office of Foreign Assets Control of the Department of the Treasury).

[X] (57) 52.239-1, Privacy or Security Safeguards (Aug 1996) (5 U.S.C. 552a).

(b) The Contractor shall comply with the FAR clauses in this paragraph (c), applicable to commercial services, that the Contracting Officer has indicated as being incorporated in this contract by reference to implement provisions of law or Executive orders applicable to acquisitions of commercial items:

[X] (1) 52.222-17, Nondisplacement of Qualified Workers (May 2014)(E.O. 13495).
[X] (2) 52.222-41, Service Contract Labor Standards (May 2014) (41 U.S.C. chapter 67).
[X] (3) 52.222-42, Statement of Equivalent Rates for Federal Hires (May 2014) (29 U.S.C. 206 and 41 U.S.C. chapter 67).
[X] (4) 52.222-43, Fair Labor Standards Act and Service Contract Labor Standards-Price Adjustment (Multiple Year and Option Contracts) (May 2014) (29 U.S.C. 206 and 41 U.S.C. chapter 67).
[X] (8) 52.222-55, Minimum Wages Under Executive Order 13658 (Dec 2015).

(c) Comptroller General Examination of Record. The Contractor shall comply with the provisions of this paragraph (d) if this contract was awarded using other than sealed bid, is in excess of the simplified acquisition threshold, and does not contain the clause at 52.215-2, Audit and Records—Negotiation.

(1) The Comptroller General of the UBH States, or an authorized representative of the Comptroller General, shall have access to and right to examine any of the Contractor's directly pertinent records involving transactions related to this contract.

(2) The Contractor shall make available at its offices at all reasonable times the records, materials, and other evidence for examination, audit, or reproduction, until 3 years after final payment under this contract or for any shorter period specified in FAR subpart 4.7, Contractor Records Retention, of the other clauses of this contract. If this contract is completely or partially terminated, the records relating to the work terminated shall be made available for 3 years after any resulting final termination settlement. Records relating to appeals under the disputes clause or to litigation or the settlement of claims arising under or relating to this contract shall be made available until such appeals, litigation, or claims are finally resolved.

(3) As used in this clause, records include books, documents, accounting procedures and practices, and other data, regardless of type and regardless of form. This does not require the Contractor to create or maintain any record that the Contractor does not maintain in the ordinary course of business or pursuant to a provision of law.

(e)(1) Notwithstanding the requirements of the clauses in paragraphs (a), (b), (c), and (d) of this clause, the Contractor is not required to flow down any FAR clause, other than those in this paragraph (e)(1) in a subcontract for commercial items. Unless otherwise indicated below, the extent of the flow down shall be as required by the clause—

(vi) 52.222-40, Notification of Employee Rights Under the National Labor Relations Act (Dec 2010) (E.O. 13496). Flow down required in accordance with paragraph (f) of FAR clause 52.222-40.

(i) 52.222-41, Service Contract Labor Standards (May 2014) (41 U.S.C. chapter 67). (xi) 52.203-13, Contractor Code of Business Ethics and Conduct (Oct 2015) (41 U.S.C. 3509).

(ii) 52.219-8, Utilization of Small Business Concerns (Nov 2016) (15 U.S.C. 637(d)(2) and (3)), in all subcontracts that offer further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds $700,000 ($1.5 million for construction of any public facility), the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.

(iii) 52.222-17, Nondisplacement of Qualified Workers (May 2014) (E.O. 13495). Flow down required in accordance with paragraph (l) of FAR clause 52.222-17.

(iv) 52.222-21, Prohibition of Segregated Facilities (Apr 2015)

(v) (v) 52.222-26, Equal Opportunity (Sept 2016) (E.O. 11246).

(vii) 52.222-35, Equal Opportunity for Veterans (Oct 2015) (38 U.S.C. 4212).

(viii) 52.222-36, Equal Opportunity for Workers with Disabilities (Jul 2014) (29 U.S.C. 793).

(ix) 52.222-37, Employment Reports on Veterans (Feb 2016) (38 U.S.C. 4212)

52.222-50, Combating Trafficking in Persons (Mar 2015) (22 U.S.C. chapter 78 and E.O 13627).

Alternate I (Mar 2015) of 52.222-50 (22 U.S.C. chapter 78 and E.O 13627).

(xii) 52.222-51, Exemption from Application of the Service Contract Labor Standards to Contracts for Maintenance, Calibration, or Repair of Certain Equipment-Requirements (May 2014) (41 U.S.C. chapter 67).

(xiii) 52.222-53, Exemption from Application of the Service Contract Labor Standards to Contracts for Certain Services-Requirements (May 2014) (41 U.S.C. chapter 67).

(xiv) 52.222-54, Employment Eligibility Verification (Oct 2015) (E.O. 12989).

(xv) 52.222-55, Minimum Wages Under Executive Order 13658 (Dec 2015).

(xvi) 52.225-26, Contractors Performing Private Security Functions Outside the UBH States (Oct 2016) (Section 862, as amended, of the National Defense Authorization Act for Fiscal Year 2008; 10 U.S.C. 2302 Note).

(xvii) 52.226-6, Promoting Excess Food Donation to Nonprofit Organizations (May 2014) (42 U.S.C. 1792). Flow down required in accordance with paragraph (e) of FAR clause 52.226-6.

(xviii) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (Feb 2006) (46 U.S.C. Appx. 1241(b) and 10 U.S.C. 2631). Flow down required in accordance with paragraph (d) of FAR clause 52.247-64.

(2) While not required, the Contractor may include in its subcontracts for commercial items a minimal number of additional clauses necessary to satisfy its contractual obligations.

(End of Clause)

Standard Payment Appendix
United Behavioral Health ("UBH")
FS 6054 N STD 1.00 Commercial Fee Schedule

Applicability

This Payment Appendix applies to Mental Health and Substance Use Disorder (MHSUD or MHSA) Covered Services rendered by Contracted Behavioral Health Providers and Medical Group Professionals, also known as Providers under the Benefit Plans as described in the Agreement.

Provider reimbursement under this Payment Appendix is limited to [Behavioral Health Professionals, Health Professionals] delivering MHSUD Covered Services as defined by the Member's Benefit Plan and delivered by an appropriately licensed Behavioral Health Provider under this Agreement. MHSUD Services are also known as Covered Services and Health Services.

Section 1
Contract Rate for Covered Services

1.1 Contract Rate. For Covered Services rendered by Provider to a Member, Payor will pay the lesser of Provider's billed charges for Covered Services or the applicable contract rate determined in accordance with the Contract Rate Table. Payment under this Payment Appendix will be less any applicable co-payments, deductibles and coinsurance and is subject to the requirements set forth in the Agreement and in accordance with the Payor's Reimbursement Policies.

Contract Rate Table.

UNITED BEHAVIORAL HEALTH (OHBS) Fee Schedule Maximums					
FS 6054 N STD 1.00					
Modifier 1	**Modifier 2**	**Modifier 3**	**Service Code**	**Service Title/Description**	**Fee: MA**
			90785	Interactive complexity	$11.57
			90791	Psychiatric Diagnostic Evaluation without Medical Services	$106.93
			90792	Psychiatric Diagnostic Evaluation with Medical Services	$119.63
			90832	Psychotherapy, 30 Min.	$51.92
			90833	Psychotherapy pt&/fam w/e&m 30 min	$0.00
			90834	Psychotherapy, 45 Min.	$69.41
			90836	Psychotherapy pt&/fam w/e&m 45 min	$0.00
			90837	Psychotherapy, 60 Min.	$104.11
			90838	Psychotherapy pt&/fam w/e&m 60 min	$0.00
			90839	Psychotherapy for crisis, first 60 min.	$108.63
			90840	Psychotherapy crisis each additional 30 min	$51.92

			90846	Family Psychotherapy, without pt present	$83.80
			90847	Family/Couple Psychotherapy	$87.18
			90849	Multiple-family Group Psychotherapy	$40.00
			90853	Group Psychotherapy	$40.00
			90863	Pharmacologic mgmt with psychotherapy	$0.00
			90870	ECT, single seizure and multiple seizure per day	$0.00
			90901	Biofeedback	$60.00
			96112	Devel tst phys/qhp 1st hr	$0.00
			96113	Devel tst phys/qhp ea addl	$0.00
			96116	Neurobehavioral Status Exam with interpretation and report per hour	$0.00
			96121	Neurobehavioral status exam by professional; each add'l hour	$0.00
			96130	Psychological testing evaluation services by professional; first hour	$0.00
			96131	Psychological testing evaluation services by professional; each add'l hour	$0.00
			96132	Neuropsychological testing evaluation services by professional; first hour	$0.00
			96133	Neuropsychological testing evaluation services by professional; each add'l hour	$0.00
			96136	Psych./Neuropsych. test admin. & scoring by professional, two; tests; first 30 mins	$0.00
			96137	Psych./Neuropsych. test admin. & scoring by professional, two; tests; each add'l 30 mins	$0.00
			96138	Psych./Neuropsych. test admin. & scoring by tech., two; tests; first 30 minutes	$0.00
			96139	Psych./Neuropsych. test admin. & scoring by tech., two; tests; each add'l 30 mins	$0.00
			96146	Psych./Neuropsych. test admin. w/single instrument, electronic platform, w/automated result	$0.00
			96156	H&B Assessment or reassessment, untimed	$78.35
			96158	H&B Intervention individual, 30 minutes	$53.46
			96159	H&B Intervention individual, add on at 15 minutes	$18.67
			96164	H&B Intervention 15 minutes, group	$7.92

			96165	H&B Intervention, Group add on at 15 minutes	$3.68
			96167	H&B Intervention family with patient, 30 minutes	$57.42
			96168	H&B Intervention family with patient, add on at 15 minutes	$20.36
			96170	H&B intervention family w/out patient, 30 minutes	$65.06
			96171	H&B intervention family w/out patient add on at 15 minutes	$23.76
			96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	$0.00
			99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	$0.00
			99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	$0.00
			99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	$0.00
			99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	$0.00
			99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	$0.00
			99212	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	$0.00
			99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29	$0.00

				minutes of total time is spent on the date of the encounter.	
			99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	$0.00
			99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	$0.00
			99221	Initial Hospital Care (30 min.)	$80.98
			99222	Initial Hospital Care (50 min.)	$109.19
			99223	Initial Hospital Care (70 min.)	$161.95
			99231	Subsequent Hospital Care (15 min.)	$0.00
			99232	Subsequent Hospital Care (25 min.)	$0.00
			99233	Subsequent Hospital Care (35 min.)	$0.00
			99234	Observation or I/P hosp care including admission & discharge on the same day low severity	$0.00
			99235	Observation or I/P hosp care including admission & discharge on the same day moderate severity	$0.00
			99236	Observation or I/P hosp care including admission and discharge on the same date	$0.00
			99238	Hospital Discharge Services	$0.00
			99239	Hospital Discharge Services (greater than 30 mins)	$0.00
			99241	Office/Other Outpt Consult (15 min.)	$0.00
			99242	Office/Other Outpt Consult (30 min.)	$0.00
			99243	Office/Other Outpt Consult (40 min.)	$0.00
			99244	Office/Other Outpt Consult (60 min.)	$0.00
			99245	Office/Other Outpt Consult (80 min.)	$0.00
			99251	Initial Inpatient Consult (20 min.)	$38.94
			99252	Initial Inpatient Consult (40 min.)	$59.53
			99253	Initial Inpatient Consult (55 min.)	$91.70

			99254	Initial Inpatient Consult (80 min.)	$133.17
			99255	Initial Inpatient Consult (110 min.)	$160.26
			99281	Emergency Room Visit - straightforward problem focused exam	$16.93
			99282	Emergency Room Visit - expanded problem focus - low	$33.01
			99283	Emergency Room Visit - expanded problem focus - moderate	$49.38
			99284	Emergency Room Visit - detailed exam - moderate complexity	$93.67
			99285	Emergency Room Visit - detailed exam - urgent and comprehensive	$137.97
			99304	Nsg Facility Assessment Low	$72.79
			99305	Nsg Facility Assessment Moderate	$104.11
			99306	Nsg Facility Assessment High	$133.17
			99307	Subsequent Nsg Facility Care (10 min.)	$35.55
			99308	Subsequent Nsg Facility Care Low (15 min.)	$55.30
			99309	Subsequent Nsg Facility Care Moderate (25 min.)	$73.08
			99310	Subsequent Nsg Facility Care High (35 min.)	$108.63
			99318	E&M N/E Annual Nurse Facility	$76.74
			99324	Domiciliary or rest home visit for the evaluation and management of a new patient. (20 Minutes)	$44.02
			99325	Domiciliary or rest home visit for the evaluation and management of a new patient (30 minutes)	$64.05
			99326	Domiciliary or rest home visit for the evaluation and management of a new patient (45 minutes)	$111.17
			99327	Domiciliary or rest home visit for the evaluation and management of a new patient (60 minutes)	$148.69
			99328	Domiciliary or rest home visit for the evaluation and management of a new patient (75 minutes)	$174.09
			99334	Domiciliary or rest home visit for the evaluation and management of an established patient (15 minutes)	$47.97
			99335	Domiciliary or rest home visit for the evaluation and management of an established patient (25 minutes)	$75.62
			99336	Domiciliary or rest home visit for the evaluation and management of an established patient (40 minutes)	$108.06

			99337	Domiciliary or rest home visit for the evaluation and management of an established patient (60 minutes)	$154.34
			99341	Home Visit - New Pt/low severity	$0.00
			99342	Home Visit - New Pt/moderate severity	$0.00
			99343	Home Visit - New Pt/high severity	$0.00
			99347	Home Visit - Established Pt/stable	$0.00
			99348	Home Visit - Established Pt/poor response to tx	$0.00
			99349	Home Visit - Established Pt/signi. complication	$0.00
			99350	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family	$0.00
			99383	Inpatient History and Physical- initial (5-11 yrs)	$0.00
			99384	Inpatient History and Physical- (12-17 yrs)	$0.00
			99385	Inpatient History and Physical- (18-39 yrs)	$0.00
			99386	Inpatient History and Physical- (40-64 yrs)	$0.00
			99408	Alcohol/SA abuse(other than tobacco) screening & brief intervention. 15-30 minutes	$28.22
			99409	Alcohol/SA abuse(other than tobacco) screening & brief intervention. > 30 minutes	$54.74
			99441	Telephonic evaluation 5-10 minutes	$11.29
			99442	Telephonic evaluation 11-20 minutes	$21.44
			99443	Telephonic evaluation 21-30 minutes	$31.60
			H0031	MH Assessment by Non-Physician (per Hour). Direct Services for Assessment/Treatment Planning by BCBA or licensed MH clinician, per hour.	$0.00
		HN	H0031	MH Assessment by Non-Physician (per Hour). Direct Services for Assessment/Treatment	$0.00

				Planning by BCaBA, per hour.	
			H0032	MH Service Plan Development by Non-Physician (per Hour). Supervision of Paraprofessional by BCBA or licensed MH clinician; per hour (services rendered jointly, in-person, during directly supervised fieldwork of the Paraprofessional by the Supervisor)	$0.00
		HN	H0032	MH Service Plan Development by Non-Physician (per Hour). Supervision of Paraprofessional by BCaBA; per hour (services rendered jointly, in-person, during directly supervised fieldwork of the Paraprofessional by the Supervisor)	$0.00
		HA	H2014	MH Skills Training and Development (15 Min.). Social Skills Group (multi child & staff), per 15 minutes.	$0.00
			S9485	Crisis intervention mental health services, per diem	$0.00
			H2012	MHSA Day Treatment (per Hour). Direct ABA Services by BCBA or licensed MH clinician, per hour.	$0.00
			H2019	MH Therapeutic Behavioral Services (15 Min.). Services by ABA Paraprofessional, per 15 minutes.	$0.00
			OTP Codes	null	
			H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program	$0.00
			H0033	Oral medication administration, direct observation	$0.00
			H0047	Alcohol and/or other drug abuse services, not otherwise specified	$0.00
			MAT Induction	null	
			99354	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient Evaluation and Management or psychotherapy service, except with office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215])	$0.00
			99355	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)	$0.00
			Spravato	null	

			Codes		
			99358	Prolonged evaluation and management service before and/or after direct patient care; first hour	$0.00
			99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)	$0.00
			99415	Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)	$0.00
			99416	Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service)	$0.00
			99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)	$0.00
			G2212	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patients single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)	$0.00

Section 2
Miscellaneous Provisions

2.1 Inclusive Rates. The contract rates established by this Payment Appendix for the service categories listed in the Contract Rate Table are all-inclusive, and represent the entire payment for the provision to the Member of all Covered Services that are in the given service category, including those Covered Services that are generally provided as a part of the service in the given service category. All items and non-physician services provided to Members must be directly furnished by Provider or billed by Provider when services are provided by another entity. No additional payments will be made for any services or an item covered under the Member's Benefit Plan and billed separately by Provider.

Should Provider bill codes that are not on the Contract Rate Table, then Provider agrees to accept zero payment. If Provider bills codes that are on the Contract Rate Table but the services were not rendered by credentialed Provider, then Provider agrees to accept zero payment. Provider shall have the opportunity to submit corrected claims according to the terms of the Agreement. Nothing herein prohibits Provider from billing any Member for Non-Covered Services if the Member has agreed in writing after services are determined to be Non-Covered Services to accept financial responsibility for such Non-Covered Service.

2.2 Billing and Filing of Claims. Provider will submit claims using a CMS 1500, its successor form or its electronic equivalent. All claims submitted under this Payment Appendix must include required CPT Codes, HCPCS Codes, ICD Codes or its successor and other codes in compliance with HIPAA standard data set requirements. Claims submitted without HIPAA standard data set requirements may be denied.

2.3 Payment Code Updates. UBH will update any codes, such as Revenue Codes, ICD Codes or successor version, HCPCS Codes, CPT Codes and/or POS Codes, from time to time according to changes in the industry, including among other things (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD or successor version which is issued by the U.S. Department of Health and Human Services, and (d) the latest guidelines from the National Uniform Billing Committee.

Unless specified elsewhere in this Payment Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified.